PRINTED: 07/07/2022 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495203	B. WING			C 8/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP COI 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000		
F 000	survey was conducte 6/29/2022. The faciliti compliance with 42 C Requirement for Long	y was in substantlal FR Part 483.73, -Term Care Facilities.	F	000		
	survey was conducte Corrections are required. CFR Part 483 Federa requirements. Three investigated during the (VA00053324-substa VA00055516-unsubsta	complaints were e survey ntiated without deficiency; antiated; antiated). The Life Safety				
	101 at the time of the consisted of 33 currer closed record reviews Reasonable Accomm CFR(s): 483.10(e)(3) §483.10(e)(3) The rig services in the facility accommodation of repreferences except wendanger the health cother residents. This REQUIREMENT by: Based on observation interview, facility doctorecord review, it was	odations Needs/Preferences ht to reside and receive with reasonable sident needs and	F	1. Resident #1was provide chair and family was inform Reclining is stored closed of floor solarium when not in educated on the location of prevent to misconception to chair. 2. All residents requiring the reclining chair to be out of be impacted by the alleged practice. A quality review was conducted to the end of the course there chair made available for the	ned. The to the second use. Family f the chair to hat there is no the use of a bed are at risk to deficient ucted on clining chair to g is a reclining	
ABORATORYI	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) dehotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient projection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. 00/LON		С		
		495203	B. WING		06/29	/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP COD 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR CORRECTIVE ACTION : CROSS-REFERENCED TO THE	SHOULD BE HEAPPROPRIATE	(X5) COMPLETI ON DATE	
	Continued From pareclining chair for a survey sample, Refalled to provide a the resident to get. The findings included the resident to get. The findings included the resident to get. The findings included the resident MDS (minimals assessment with a date) of 3/14/22, Recognitive impalmed R1 was coded as massistance of staff bed to chair. R1 was observed times: 6/27/22 at 1 6/28/22 at 9:29 a.m. sitting up in bed, we feeding running, at 2 liters per minute supported in bed be positioning device place to prevent further unavailable for interviewed. R1's sabout R1's care at staff had not gotter.	age 1 one of 39 residents in the esident #1 (R1). The facility staff reclining chair for R1 to enable out of bed.	TAG	CROSS-REFERENCED TO TH	ces/Unit Managers ation of resident cors. ces/Unit Manager ing audits weekly or 2 months to clining chair and all the resident to get out of bed. s to the QAPI uality Monitoring		
	A review of R1's cl	inical record revealed the larged to the hospital on 6/7/22 the facility on 6/14/22.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495203	B. WING _			C 06/29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 558	Continued From pag	e 2	F	558	-		
	daily living) records f	nt of care/ADL (activities of for June 2022 revealed no s transferred from bed to 22 and 6/27/22.					
	assistant) #2 was intook care of R1 frequent haven't been getting chair situation." When information, she state chair in order to get a chair "disappeared" hospital, and the state another one for their resident usually gets usually gets out of be and Friday. She state happened to R1's regresident went to the	ed R1 needed a reclining out of bed. She stated R1's while the resident was in the ff has not been able to find esident. When asked if the out of bed, she stated R1 ed on Monday, Wednesday, ed she did not know what clining chair when the hospital. When asked if she anyone, she stated she had					
	rehabilitation, was in was familiar with R1, at the facility for seventhought R1 did not rebut only required a grated he had never facility's reclining charmed and reclining charms and charms then to the executive director. Hence a therapy screen was familiar to the executive director.	.m., OSM #3, the director of terviewed. OSM #3 stated he as R1 had been a resident eral years. He stated he equire a specially fitted chair, eneric reclining chair. He encountered issues with the air supply. He stated, "I think in floor." He stated if a new eded, he goes first to the unit edirector of nursing or the le stated the resident did not ening or referral in order to be r by nursing from bed to a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					i c	;	
		495203	495203 B. WING		06/2	9/2022	
	ENVOY OF ALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVI CROSS-REFERENCE:	NO OF CORRECTION EACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 558	Continued From p	age 3	F t	558			
	nurse) #1, the interinterviewed. She is R1's need for a rechad arrived at the was discharged to had an immediate the staff gave that She stated, "We hat one reclining clooking into getting stated she is "talki director) about it." director has to get stated she had spenda asked OSM # procurement of the OSM #9, central is whether a new characterism whether a result in the constant of the constant	a.m., LPN (licensed practical rim unit manager, was stated she just became aware of clining chair one the surveyors building. She stated when R1 the hospital, another resident need for a reclining chair, and resident R1's reclining chair, and resident R1's reclining chair. ad to make a choice. We had chair." She stated, "They are g a new chair for [R1]." She ing to our ED (executive She stated the executive approval for the purchase. She can earlier with OSM #3, and 3 to help expedite the executive recliner chair. She stated upply clerk, would know air had been ordered yet.	The second secon				
	On 6/29/22 at 12:3 staff member) #1, the director of nurs	ated a new recliner chair had ed. 19 p.m., ASM (administrative the executive director, ASM #2, sing, and ASM #4, the regional services, were informed of					
	Accommodation of information related	rility policy, "Social Services - f Needs," revealed no I to the provision of medical t the needs of the resident.					
F 600 SS=G		tion was provided prior to exit. and Neglect	F	600			

PRINTED: 07/07/2022 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO	0. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
						c		
		495203	B. WING		06/	29/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
ENVOY O	FALEXANDRIA, LLC			900 VIRGINIA AVENUE				
	THE POTON LEG			ALEXANDRIA, VA 22302				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE PPROPRIATE	(X5) COMPLETION DATE		
				1. Resident #44 was seen an		8/3/2022		
F 600	Continued From page	4	F	600 by social worker and geriatric				
	CFR(s): 483.12(a)(1)			doctor to ensure resident feel				
			į	there was not emotional traur		İ		
	§483.12 Freedom fro	m Abuse, Neglect, and		Resident #44 stated that he fo				
	Exploitation			the facility and denies any em				
		right to be free from abuse,		trauma. Resident #37 no long	jer resides at			
		tion of resident property,		the center.	an loomantant but			
		efined in this subpart. This		All residents are at risk to the alleged deficient practice.				
	includes but is not lim		A quality review was conducted by the					
		involuntary seclusion and	İ	Director of Clinical Services/S				
	treat the resident's m	ical restraint not required to		focusing on abuse and negle		4		
	Treat the resident's in	edicai symptoms.		were conducted for all resider		i		
	§483.12(a) The facility must-		1	score of 9 and higher regarding		i		
	3	,	1	abuse/neglect and feeling saf				
	§483.12(a)(1) Not use	e verbal, mental, sexual, or		facility. Residents with a BIM				
	physical abuse, corpo		E.	than 9 had skin evaluations o	ompleted to			
	involuntary seclusion;			determine if there were any s	igns of			
	This REQUIREMENT	is not met as evidenced		abuse/neglect present.		* :		
	by:			Director of Clinical Service		1		
	Based on resident in	terview, staff interview,	Services will educate all staff regarding					
		ew and clinical record review	1	monitoring and reporting of a				
		t the facility failed to protect		neglect in a timely manner. E				
		the survey sample from		Director and Social Services				
		buse, Resident #44. On		residents on next Resident C	•			
		7 hit Resident #44, which		regarding reporting any issue				
- 6		cy room visit where they		residents or staff to the Supe	rvisor or Social			
	-	a closed fracture of the		Worker.	-/0!-!	9		
		Ina (1), closed head injury,		4. Director of Clinical Service		1		
	nasal bone, resulting	and a closed fracture of the		Services will conduct quality in		1		
	i iasai bulle, resulting	u) nailli.		audits for abuse and neglect weeks and then monthly for 2		4		
	The findings include:			Director of Clinical Services v		I		
	The intuitige include.							
	Resident #44's (R44)	most recent MDS	findings to the QAPI Committee monthly for 3 months to maintain substantial					
		an annual assessment with		compliance.	HILA	!		
		reference date) of 5/1/2022,		portipiidatioo,				
		5 out of 15 on the BIMS		1				
	ŷ*	intal status \ assessment				1		

indicating the resident is cognitively intact for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTI	(X3) DATE SURVEY COMPLETED	
			A BOILDIN		С
		495203	B. WING_		06/29/2022
	ROVIDER OR SUPPLIER F ALEXANDRIA, LLC		w	STREET ADDRESS, CITY, STATE, ZIP C 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	ODE
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THEAPPROPRIATE DATE
F 600	Continued From p	age 5	= F6	son -	
. 555		sions. Section E documented	F		
		ction G documented R44			i i
		ion with transfers, walking in the			4
		s and locomotion on and off the			
		s and locomotion on and on the ocumented R44 not having any		1	
		functional range of motion to			
		er extremities and being not			1
		stabilize without staff	1		37
	assistance when v		1		Ť
	40010141100 1111011			-	Ÿ.
	On 6/27/2022 at 5	:14 p.m., an interview was	4	*	1
		14 in their room. R44 was			
		ped and was observed to have	1		
		vith an elastic bandage on the			
		n asked about the splint on the			
		tated that they were hit by			
		vith a cane in the solarium at		1	
	the end of the hall	way the previous Friday. R44		:	
		ad a fracture in the arm and a			
		m the incident. R44 stated that		1	
	they had gone to t	he emergency room and they		1	i i
	had taken x-rays,	applied the splint and advised	3		1
	them to follow up	with an orthopedic physician to			
	see if they needed	surgery or not. When asked		4	i.
		who hit them, R44 indicated	1		i
		(R37) had approached them in			i
		started hitting them with a cane			i i
		I they were "crazy." R44 stated			
		keeping R37 in their room and			
	were watching the	em all the time after the incident.		3	
	The greeness sate	on for Dooldook #444 doorwood o			
		es for Resident #44 documented			
	ાંn part, ં_ "દ <i>ાગ∧ા</i> ગગગ ગ∩∗4લ	(9:10 n m) Note Tout			
		9 (8:19 p.m.) Note Text: respiratory distress noted.			i i
		nurses station with blood on his			# # # # # # # # # # # # # # # # # # #
		nurses station with blood on his lises and bump (swelling)		₩	
		sident c/o (complains of) pain of		1	13
		stated he was lying on couch	6		1
	ion ann. Resident	Stated He was TYTHY OH COUCH	11.5	7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED	
		495203	B. WING		C 06/29/2022		
	ROVIDER OR SUPPLIER			900 VII	TADDRESS, CITY, STATE, ZIP CODE RGINIA AVENUE ANDRIA, VA 22302	06/29/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 600	Continued From page	ane 6		200		7/1	
1 000			F-1	800		37	
		solarium when resident [Room			X		
	number identifying R37] approached and accused					i i	
	him of messing up						
	Nursing supervisor						
	DON (director of n		3				
	Resident sent to E		132		1		
	evaluation and trea		35				
	- "6/25/2022 00:20				3		
		n [Name of hospital] with the					
		d fracture of distal end of left ose, closed fracture of nasal					
		injury. New order of		į.		4	
		inate (Augmentin) 875-125mg	1				
		outh 2 times daily for 7 days.		- 1		4	
		ain at this time, back in his					
	room at this time w	vill continue to monitor."	1	1		4	
		(4:16 p.m.) Note Text:					
		view today with DSS (director	2	1			
		about what happened between					
		esident. Resident told writer		1			
		esident told writer is feeling		1			
		lent told writer he feel safe at		4			
		it this time. Resident told writer					
		r will continue to support	1			39	
	resident as needed		#	18			
				- 5		1	
	The "After Visit Su	mmary" dated 6/24/2022 for				1	
		f hospital] documented in part,	1				
		: Facial laceration, arm injury.					
		fracture of distal end of left	1				
	ulna, unspecified fr	racture morphology, initial					
	encounter, closed	head injury, initial encounter,	4				
		nitial encounter, closed fracture					
		al encounterlmaging results:					
		ero anterior) lateral and					
		t) Redemonstrated mildly		- 1		3	
		cture. No additional fracture or					
		Marked vascular calcifications		1		1	
	are presentForea	arm complete Left (final result)	0.00	1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
						С		
		495203	B. WING				29/2022	
NAME OF PR	ROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP CODE	•		
ENVOY O	FALEXANDRIA, LLC			900 VIR	RGINIA AVENUE			
	The state of the s			ALEXA	ANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 7	i e	600				
		re 2. Dedicated 4 view study	•	je				
		nended to better evaluate	ė.					
		l evaluate for underlying		1				
		.CT (computed tomography)	*					
		t (final result) 1. No acute						
		lty. 2. Right nasal bone						
		compared to the prior						
	exam"	, ,						
	Resident #37's (R37)	most recent MDS, a						
	quarterly assessment	t with an ARD of 4/2/2022,						
	the resident scored 1	5 out of 15 on the BIMS	4	1				
	assessment, indicatir	ng the resident is cognitively		1				
	Intact for making daily	y decisions. Section E						
	documented no beha			-				
		uiring supervision with		:				
	_	the room and corridors and	i					
		I the unit. Section G further	1	1				
		ng not steady but able to		1				
		assistance with walking and		1				
	_	limitation in range of motion		F				
		extremities. Section G						
	documented R37 usid	ng a waiker.	i					
	On 8/27/2022 at 1:58	p.m., an interview was	15					
		n their room. R37 was						
		taff member sitting outside						
		monitoring the room. R37					1	
		us Friday they had a fight		i				
		who lived across the hall.		1				
		olice had come and the						
	· ·	vised them they were going	14					
		ner room. R37 stated that	10					
		ind why they were made to		151			1	
		d not allowed to go outside to		1			1	
		ids because they were only		i			1	
		selves. R37 stated that the		i				
		m in their chest when they						
		on and they had to fight back		1	29		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405000	485262 B WING			С	
NAME OF B	DOMEST OF ALICE	495203	B. WING			06/29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From page	e 8 s. R37 stated that they were	F	600			
	disappointed because around the facility cur friends. When asked R37 stated that it was across the hall with the stated that they did now. R37 stated that making the fight into	e they were not able to walk rrently or visit with their labout the other resident, is the resident in the room ne cast on the arm. R37 ot know why they had a cast to the facility staff were a bigger deal than it needed were just trying to defend					
	in part: - *6/28/2022 13:46 (1 Addendum- On 6/24/ number identifying R4 with blood on his nos (swelling) behind his blood on his shirt. Re identifying R44] c/o p	2022 resident [Room 44] came to nurses station				The state of the s	
	on the couch watchin above resident [Roor approached and accepuzzle in the solarium R44] stated he did not puzzle. Then [Room struck [Room number walking cane repeated identifying R44] state cover and protect his identifying R37] then number identifying R4 reported writer. Write who then reported to Resident [Room number latent is the state of the state	ng TV in the solarium when m number identifying R37] used him of messing up his in. [Room number identifying sold know anything about his number identifying R37] if identifying R44] with his idely. [Room number id he used his left arm to face. (Room number hit his arm too. [Room if called nursing supervisor DON and called 911. Iber identifying R44] was pital] ER (emergency room)					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	unec.			(X3) DATE SURVEY COMPLETED		
			A. BUILDII	NG	"			
		495203	B. WING			C		
NAME OF P	ROVIDER OR SUPPLIER			STREET ANDRESS CITY STATE 78		6/29/2022		
NAME: OF FI	NOVIDER OR SUFFLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE			
ENVOY O	FALEXANDRIA, LLC		1	900 VIRGINIA AVENUE				
				ALEXANDRIA, VA 22302	<u></u>			
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 600	Continued From pa	age 9	- F(600				
	•	(11:47 p.m.) Note Text:				1		
		ed from room [Room number]						
		with all medications and	35					
	personal belonging					i		
		(6:25 p.m.) Late Entry: Note		1		İ		
		interviewed 6/27/22 about		Ī		1		
		tween himself and another		1		!		
		agreed to move to another	3	1		i		
		nelter] was contacted to see if		3				
	· ·	nent for resident. Writer left a				1		
		of Shelter] was contacted as	- 1					
		ent and writer was told no bed	111	1		i		
	is available at this		T.	8				
	-"6/27/2022 15:00	(3:00 p.m.)Behavioral	-					
		socially inappropriate	i i			1		
		d door on staff when angry and	İ			1		
	yelling at staff"			HC.		Ī		
	- "6/27/2022 01:43	(1:43 a.m.) Note Text:		Ť				
	Resident called for	pain medication for	!			4		
	generalized pain a	t 1:25 am. Writer was on						
	[Name of unit] finis	hing up with another resident.	İ			1		
	Writer went to [Nai	me of unit] at 1:30am to give				1		
		Percocet. While checking	ļ					
		pull medication, resident	l l					
	walked from his ro	om to the nurses station and	1					
	started yelling and	cursing writer out. Resident						
		been waiting 15 minutes for						
		and give him his Percocet.						
		I medication out of nurses						
		er and told nurse, "you drink it."	9	8				
		ack to his room and slammed				4		
		up with resident immediately	21					
		s taken. Resident remains in	1					
		Writer will check on resident				1		
		calmed down to check on his				- 1		
	pain. Supervisor n		1					
		(7:19 a.m.) Note Text: At	1					
		It his room stating his going	1	:		Si		
	outside to get fresi	h air, resident was told to wait	10.1					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495203	95203 B. WING		C 06/29/2022	
NAME OF PROVIDER OR SUPPLIER ENVOY OF ALEXANDRIA, LLC			·	STREET ADDRESS, CITY, STATE, ZIP CO 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE COMPLETION HE APPROPRIATE DATE	
F 600	Continued From pa	ge 10	F	600		
	too. Resident state was told how unsat of the night. Supen resident went outsi at 4:10am. He is in continue to monitor - "6/23/2022 10:28 Resident and I calle volcemail. Residen give them a call late.	(10:28 a.m.) Note Text: ed [Name of Shelter] and left a t was provide the number to er. Writer and I called have	The state of the s			
	days with no respondays with no respondance of 16/2022 11:00 problems are verbacursing, etc.) Screat Language told write where you came from his door" - "5/4/2022 21:59 (19/2022 11:59)	Name of Shelter] for the few nse. Writer left a voicemail." (11:00 a.m.)Behavioral libehaviors (screaming, aming at Writer using foul er "you are an animal go back om" with expletives. Slamming				
	hostile to staff. Psy to have mental cap Patient is not safe to be a risk to other re-"5/4/2022 09:34 (the door in my face his tray on the treal cannot I asked him please" He handed the door in my face -5/3/2022 18:13 (6 approximately 2300 (5/2/2022), the everthat the damaged is after resident pourse.	9:34 a.m.) Note Text: slammed . Resident asked if he can put the cart, I sald No, he politely "Can you give it to me the tray to me and slammed ." :13 p.m.) Note Text: At 0 (11:00 p.m.) on 5/2 ning nurse notified this writer aptop was no longer working and water on it. Writer notified				
	the police who retu	med to the facility at 0700 5/3/2022) to document the	1	1		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:				(X3) DATE SURVEY COMPLETED		
			A. BOILD					
		495203 B. WING					2022	
NAME OF PRO	VIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	00/28/	2022	
					RGINIA AVENUE			
ENVOY OF A	ALEXANDRIA, LLC				(ANDRIA, VA 22302			
				ALEX	<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETION DATE	
F 600	Continued From page	∍ 11	: - F	600 600				
c	destruction of propert	y. Police stated that writer	- 1	İ				
		nagistrate independently to		!				
	_	or misdemeanor destruction						
	-	lcers spoke with resident in		ļ				
		riter. Resident recounted		ļ				
. t	he events of the prev	vious night in great detail	19					
		, "what happened with the	1					
· v	vater and the cart". F	Resident began stating he	- 1					
44	knew nothing" about	that started to become	1	į				
8	agitated. He stood up	and left the interview		Ì				
		e going to arrest me then	- 6	1				
		her go to jail than be in the	6	1				
		rrently in room alone with		*				
		rvision to ensure safety of	ii .	1				
		sident's guardian and	9	1				
	ohysician updated on		19					
		:04 p.m.) Note Text: This		139				
		all from the nurse on		- 4				
		oximately 8:45pm. Nurse	sá					
		t was upset about pain	7					
		ninistered every 6 hours						
	nstead of every 2 ho							
		riter could hear resident		- 8				
		und loudly and calling the						
		s. Nurse reported that	3					
		ng doors, yelling loudly and						
		ne off of the wall. The nurse		3				
		ried to pull the door shut	100					
		to enter to attend to [R37]'s oreported that resident	1					
		over the ice pitcher on the						
		aging the medication laptop.	1	Pe				
		and they responded to the	i	17				
		with police officers on site						
		re is not much we can do in						
	· ·	speak with him and	. 11					
		icer reported that resident	oto					
		arrival and denied doing	18					
		dication cart. Police officer				3.5		
	and the second s			100				

OLNIER	S POR WIEDICARE & I	MEDICAID SELVICES			U	VIB NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X	(X3) DATE SURVEY COMPLETED	
		495203	B. WING	 _		C 06/29/2022	
	AME OF PROVIDER OR SUPPLIER ENVOY OF ALEXANDRIA, LLC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 12 stated the laptop remained "on" and working, but that if is [sic] stopped working to call back to document the damage. Increased supervision provided by CNAS (certified nursing assistants) during the remainder of the shift. Writer left message for resident's guardian and physician regarding his behavior. Writer also notified psych (psychiatrist), who stated he would come in the morning to see the resident." The geriatric psychiatry consult note dated 3/10/2022 for R37 documented in part, "asked to evaluate cognition. Pt (patient) is alert & engaging. Fully oriented. He admits he is easily frustrated. He feels staff "don't care." He can be very aggressive verbally. Has been known to use racial slurs, hard to direct" The geriatric psychiatry consult note dated 5/3/2022 for R37 documented in part, "Pt has been struggling, he is frustrated he is here. Feels mistreated by staff. Last week was physically aggressive [medical abbreviation for "with"] behaviors that included breaking a laptop" The comprehensive care plan for R37 documented in part, "[Name of R37] is at risk for behaviors (verbal/physical aggression, refusal of care, delusions) r/t (related to) diagnosis of adjustment disorder with disturbance of conduct, mood disorder, psychosis and major depression.	····•	STREET ADDRESS, CITY, STATE, 300 VIRGINIA AVENUE ALEXANDRIA, VA 22302	ZIP CODE			
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PROVIDER'S PLA X (EACH CORRECTIVE CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE DIENCY)	(X5) COMPLETION DATE	
E 600	Continued From page	. 10		600			
	that if is [sic] stopped document the damag provided by CNAS (conduring the remainder message for resident regarding his behavior (psychiatrist), who star morning to see the research of the serial starting of the serial starting of the serial starting psychiatrists. The geriatric psychiatrists of the evaluate cognition, engaging. Fully orient frustrated. He feels a very aggressive verbardial starting psychiatric psychiatri	working to call back to e. Increased supervision ertified nursing assistants) of the shift. Writer left 's guardian and physician or. Writer also notified psych ated he would come in the sident." try consult note dated cumented in part, "asked . Pt (patient) is alert & ated. He admits he is easily staff "don't care." He can be ally. Has been known to use irect" try consult note dated umented in part, "Pt has a frustrated he is here. Feels .ast week was physically abbreviation for "with"] ed breaking a laptop"	The second secon				
- 3	documented in part, behaviors (verbal/phycare, delusions) r/t (roadjustment disorder v	[Name of R37] is at risk for ysical aggression, refusal of elated to) diagnosis of with disturbance of conduct, nosis and major depression.					
	reported resident-res	ed in part, " [Name of R44] ident altercation that took loor solarium between				24 :	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	A. BUILDI	RIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495203	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETION
F 600	with nose bleed, and neck. [Name of R37] of R44] transferred to evaluation. Respons notified. Resident se under 1:1 observation (emergency departm facility investigation in evaluations/interview education" On 6/28/2022 at 11:0 conducted with OSM the director of social that they were not in when R37 and R44 h stated that they were the incident that day both residents on 6/2 that R37 had previou doors, destruction of verbally abusive to st displayed any aggres resident that they we OSM #10 stated that find alternate housing been to court and debeen able to find a sate the chest first when the chest first when the chest first when the cost of that the incide was not witnessed by OSM #10 stated that the incide was not witnessed by OSM #10 stated that been on 1 to 1 monitions.	ed, [Name of R44] presented a bruise to the back of his sustained no injury. [Name of the hospital for further ible party and Physician and [sic] back to their room and, one resident send to ED ent) for further evaluation, altitated including resident sets, staff interviews and staff. 5 a.m., an interview was (other staff member) #10, services. OSM #10 stated the facility on 6/24/2022 and the altercation. OSM #10 called and made aware of and had followed up with 7/2022. OSM #10 stated se behaviors of slamming facility property and being aff members but had not eston towards another re aware of prior to that day. They had been attempting to go for R37 since they had emed competent but had not affed discharge location for ed that R37 was alert and the discharge location for ed that R44 had hit them in they had interviewed them on the incident. OSM #10 and staff or other residents. In since 6/24/2022, R37 had foring and staff were with from for anything. OSM #10	F.	600	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
			1.000.00	1.15a - 2.5 (2 5)	C			
		495203	B. WING_		1	29/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO				
ENVOY O	FALEXANDRIA, LLC			900 VIRGINIA AVENUE				
LINTO	FALEXANDRIA, LLO	•		ALEXANDRIA, VA 22302				
(X4) ID PREFIX TAG	(EACH DEFICI	RY STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL 'OR LSC IDEN'TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IEAPPROPRIATE	(X5) COMPLETION DATE		
F 600	Continued From p	page 14	F	600				
	behaviors and wa	s always a quiet person who		1				
		the Solarium watching		1				
	On 6/28/2022 at 1	2:54 p.m., an interview was	81					
	conducted with Li	PN (licensed practical nurse) #7.	0.50					
		at R37 had anger issues and		1				
	would throw thing	s at staff when they became	1					
		ated that there were times when	355					
		asant and charming to the staff.		1				
		at they were not aware of any	0.					
		R37 towards another resident		1				
		ation with R44 on 6/24/2022.		İ				
		at they had kept R37 in their		1				
		nonitoring and a chaperone if						
		since the altercation on	4	1		E		
		#7 stated that R44 had never		1				
		gressive behaviors and was	1			ļ		
		and friendly. LPN #7 stated		1				
		to resident altercation was and the residents were						
		vas immediately reported to the	10	4				
		or administrator. LPN #7		1				
		37 and R44 were alert and		j				
		n, place, time and situation.				:		
	- 0- 0/00/0000 -4 4							
		1:48 p.m., an interview was						
		PN #4, unit manager. LPN #4						
		nts were separated if involved in		34				
		lent altercation. LPN #4 stated would be assessed. EMS						
		cal services) and police would		:				
		ey would report the incident to				+		
		d the director of nursing. LPN	50	74				
		y would assess the residents	5)	Ŕ		1		
		behavior of the residents		\$				
	involved and keep		5.5	4				
		·						
	On 6/28/2022 at 2	2:00 p.m., an interview was	Ť					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COL	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495203	B. WING		C 06/29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC		900 V	ETADDRESS, CITY, STATE, ZIP CODE VIRGINIA AVENUE XANDRIA, VA 22302	0012572022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 600	stated that R37 wo and it was "like wal stated that R37 had and did not care. I keep other resident lashed out at the st were not aware of a residents prior to 6/ stated that R37 mo were off and on. LI had any conversatincident on 6/24/20	nge 15 N #1, unit manager. LPN #1 uld lash out at staff at times king on eggshells." LPN #1 d destroyed a facility laptop PN #1 stated that they had to its out of the way when R37 aff. LPN #1 stated that they any incidents with other 124/2022 with R37. LPN #1 stly had verbal behaviors that PN #1 stated that they had not ons with R37 since the 22. LPN #1 stated that R44 by behaviors and was always	F 600			
	conducted with ASI member) #2, the distated that R37 was court to have the gestated that R37 had laptop when the nu additional pain med R37 had been place the incident on 5/2/facility laptop and distaff. ASM #2 stated that time and R37 hithey did not remembrat R37 did not lack knew they were lying ASM #2 stated that nursing) had moved placed them on 1 to there had been no stated that they had around 5/24/2022 by	I1 p.m., an interview was of (administrative staff rector of nursing. ASM #2 is competent and had been to pardianship lifted. ASM #2 if previously damaged a facility rese would not give them lications. ASM #2 stated that ed on 1 to 1 monitoring after 2022 when they damaged the isplayed behaviors towards and lied to the police had come at read lied to the police saying ber anything. ASM #2 stated is capacity and the police go but could not do anything, the previous DON (director of dray to a private room and of monitoring at that time and further behaviors. ASM #2 if ended the 1 to 1 monitoring recause R37 was not eviors and the physician had				

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		40,5002	B. WING			С
		495203	B. WING			06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
ENVOY O	FALEXANDRIA, LLC			900 \	VIRGINIA AVENUE	
				ALE	XANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ ,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 600	Continued From page	e 16	F	300		
		uld be lifted. ASM #2 stated	' '	,00		
		the physician fax over a				
		s. ASM #2 stated that they				
		ntil late on 6/24/2022 after				
		ad left for the day before				
		he solarium. ASM #2 stated				
		er 8:00 p.m., they received a				
		scility saying that R44 had				
	been hit with a cane a					
		ted that when they arrived		- 3		
		for the hospital and R37 was				
		2 stated that they spoke with				
		aid they did it because R44				
		ASM #2 stated that R37	i			
	-	when they were told they				
		e 1 to 1 monitoring and		94		
		ther room. ASM #2 stated				
		ity prior to R44 coming back				
		M #2 stated that they saw		- 4		
		th the bruise on the neck,				
	broken nose and arm	. ASM #2 stated that they				1
	asked R44 why they	did not call for help on	ŀ	- 3		30
	6/24/2022 and what I	nappened. ASM #2 stated				18
	that R44 explained th	at R37 thought they messed		- 1		1.0
	up their puzzle. ASM	#2 stated that R44 would		3		0
	not press charges ag	ainst R37 because they did				
	not want them to get	into trouble. ASM #2 stated		- 1		
	that R37's actions we	re criminal.		- 1		
	On 6/28/2022 at 4-26	p.m., an interview was				
		(certified nursing assistant)				
		(certilled hursing assistant) lat they were working on		3		
	E-1	altercation between R37 and				12
		#9 stated that near the end				5
	1	199 were at the nurses		3		
	_	ne up to the nurses station		- 91		į.
		ise and said that R37 had hit				
		NA #9 stated that R44 had				
		ad accused them of messing				T.
	CONTROL MACE NOT HE	a accepted might of messify	i i			-

STATEMENT OF (FDEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ISTRUCTION	(X3) DATE SURVEY COMPLETED
		495203	B. WING_			C 06/29/2022
	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		VVILVILVAL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DIBE COMPLETION
The state of the s	called 911 to send R4 and they had made s and monitored 1 on 1 were no staff or reside incident. CNA #9 stardown in the solarium television. CNA #9 starbusive to staff at time at times. CNA #9 staresident altercation with mediately separate for help. CNA #9 stalincidents to the nurse	A #9 stated that the nurse had 44 to the emergency room Foure R37 was in their room 1. CNA #9 stated that there Fents who witnessed the Fitted that R44 normally sat Fevery day watching Fitted that R37 was verbally Fitted that R37 was verbally Fitted that if a resident to	F	600		
	conducted with ASM stated that they care when R37 gets emotion dangerous and verbat #5 stated that normal ASM #5 stated that R property but they did someone a concussion had not seen R37 sin with R44 but based of them they felt that even ASM #5 stated that they wanted thir and R37 needed to be #5 stated that they had on 1 monitoring to cookeep working on a sa	#5, medical doctor. ASM #5 for R37. ASM #5 stated that ional they could become ally difficult and act out. ASM illy R37 was not dangerous. R37 had destroyed some not feel that they could give on. ASM #5 stated that they not he incident on 6/24/2022 in what was going on with erything was behavioral. They felt that if R37 did not get not safely discharged. ASM ad recommended for the 1 intinue and for nursing to afe discharge. ASM #5 hat R37 did not like R44 for is mad at them.				AND AND ADDRESS OF THE PARTY OF
	The facility policy "Ab	ouse, Neglect, Exploitation &				1

OLITICIA	OT ON WEDTONINE GO	HEDIOAID SERVICES				CIVID IV	<u>J. 0930-039 I</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS			SURVEY PLETED
		495203	B. WING			I	C / 29/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
				l	GINIA AVENUE		
ENVOY O	FALEXANDRIA, LLC			l .			
			,	ALEXA	ANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 600	Continued From page	18		600			
			1	000			
•	Misappropriation" wit	ted in part, "It is inherent in	1.1				
		of each resident at the	5				
		afforded basic human		1			:
		ght to be free from abuse,		1			1
	neglect, mistreatmen	-		- A			
		ropertyAbuse is the willful		1			
		easonable confinement,		171			:
		nment with resulting physical					
	harm, pain, or mental	anguishFurthermore, the	:	:			:
		Company recognizes that	Δi.				ì
	resident abuse can b						1
	residents, visitors, or	volunteers"	- 49				1
	0-0/00/0000		1				o i
		p.m., ASM (administrative		i			
		executive director and ASM sing were made aware of		i			
	the concern for harm.						
	THE CONCENTION HAITI	•					<u>%</u>
	No further information	was provided prior to exit.					
	Reference:		4				.a M
	1. ulna						
	1	our body, three of them are	1				
		erus, radius, and ulna. this					1
1		ned from the website:					
		ov/arminjuriesanddisorders.h			•		
	, tml			4 D	legident #44 was seen and in	toniowod	i io la lacas
F 607		buse/Neglect Policies	F	607 by a	esident #44 was seen and into ocial worker and geriatric psy	ici viewed ichiatrio	8/3/2022
	CFR(s): 483.12(b)(1)				tor to ensure resident feels sa		at
					emotional trauma was sustain		7
	§483.12(b) The facilit				ident #44 indicated that he fe		t :
	: implement written pol	icies and procedures that:		the	facility and denies any emotic ma. Resident #37 is no longe	onal	
	§483.12(b)(1) Prohib		į.		dent at the center.	-	
	neglect, and exploitat		4.0				
	misappropriation of re	esident property,	100	25			

PRINTED: 07/07/2022

		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVED
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VOLABIII T	PLE CONSTRUCTION	(X3) DATE	D. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	1 ' '	IG	СОМЕ	PLETED
		495203	B. WING _		1	C /29/2022
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
				900 VIRGINIA AVENUE		
ENVOYO	ALEXANDRIA, LLC		ŀ	ALEXANDRIA, VA 22302		25
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	((EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION
				Continued From page 19		
F 607	Continued From page	19	F6	607		8/3/2022
	. •			2. All residents have the pote	ential to be	
	§483.12(b)(2) Establis	sh policies and procedures	i	impacted by the alleged defi-	cient practice.	
	to investigate any suc			Quality review conducted by	•	
				of Clinical Services/Unit Man		
	§483.12(b)(3) Include	training as required at		197		
	paragraph §483.95,			Services regarding abuse and	_	
	This REQUIREMENT	s not met as evidenced		residents. Residents with a B		,
	by:			and higher were interviewed	•	
		terview, staff interview,	Ġ.	were also questioned if they		
		ew and clinical record review at the facility staff failed to		the center. Residents with a	BIMS score of	
		e policy and procedures to	1	less than 9 had skin evaluation	ons completed	
		dents in the survey sample	1	to determine if there were a	ny signs of	1
		Resident #44. On 6/24/22,		abuse/neglect present. Qua	ity review	i
		ident #44, which required an		conducted by the Director of	•	
		t where they were diagnosed	1	Services/Unit Managers/Soc		1
		of the distal end of the left		post event management to i		1
		injury, abrasion of the nose	1	supervision of residents with		İ
	and a closed fracture	of the nasal bone.	i	3. All staff with be educated		
				1	•	
	The findings include:			Service Director and Director		4
	Decident #44le (D44)	mant was and MDC		Services/Unit Managers on:		
	Resident #44's (R44)		1	neglect, dementia behavior (_	
		an annual assessment with treference date) of 5/1/2022,	i	managing post event superv	ision.	1
		5 out of 15 on the BIMS		The interdisciplinary team w	ill review each	1
		ental status) assessment,		abuse/neglect situation to de	etermine that	4
	•	it is cognitively intact for		the appropriate post event in	nterventions	5
		s. Section E documented		are put into place as indicate		31
	no behaviors. Sectio	n G documented R44		supervision of participants.		1
		with transfers, walking in the		In the morning clinical meet	ings a review o	f
		nd locomotion on and off the		-	_	
		mented R44 not having any		residents with behaviors imp		
		ctional range of motion to		will be reviewed to ensure the	• •	
		extremities and being not		interventions are put into pl	ace to prevent	1
	steady but able to sta			abuse/neglect situations.		1
	assistance when wall	king.	- 1			i

On 6/27/2022 at 5:14 p.m., an interview was

PRINTED: 07/07/2022 FORM APPROVED OMB NO. 0938-0391

	TILDIOI IID OLIVITOLO			UMD I	IO. 0930-039 I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		E SURVEY MPLETED
	495203	B. WING			C 6/2 9/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		0120/2022
Chico of the Cathonia in a			900 VIRGINIA AVENUE		
ENVOY OF ALEXANDRIA, LLC			ALEXANDRIA, VA 22302		
(X4) ID SUMMARY ST.	ATEMENT OF DEFICIENCIES	. ID	PROVIDER'S PLAN OF CO	DESCRION	
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF	IX (EACH CORRECTIVE ACTIO	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
		1	Continued From page 20		
F 607 Continued From page	20	F	607		8/3/2022
	n their room. R44 was		4. The Executive Director/D	irector of	0/3/2022
	and was observed to have		Clinical Services/Unit Mana		F 3
	an elastic bandage on the	i	quality monitoring for abus		19
	sked about the splint on the				4
	ed that they were hit by		post event supervision wee	•	3
	a cane in the solarium at		The Executive Director/Dire		1
the end of the hallway	the previous Friday. R44	14	Services/Managers to cond	uct quality	91
stated that they had a	fracture in the arm and a	6	monitoring of residents wit	h behaviors	
fractured nose from t	he incident. R44 stated that		affecting others to ensure p	roper	
	emergency room and they		management weekly x 6 we	•	201
	lied the splint and advised		findings of these quality me		
	an orthopedic physician to		- ,	MIRORING S TO DO	d
	rgery or not. When asked		reported to the Quality		
	o hit them, R44 indicated		Assurance/Performance Im	•	
	37) had approached them in	1	Committee monthly. Qualit	y Monitoring	i i
	ted hitting them with a cane		schedule modified based or	n findings with	
	by were "crazy." R44 stated		quarterly monitoring by the	e Regional	3
	pping R37 in their room and	10	Director of Clinical Services	_	1
were watching them a	all the time after the incident.		i	/ designee.	
The progress notes for in part;	or Resident #44 documented				
- "6/24/2022 20:19 (8:	:19 p.m.) Note Text:		1		10413
	piratory distress noted.				
	ses station with blood on his	1	:		
	s and bump (swelling)				7.0
behind left ear. reside	nt c/o (complains of) pain of				
left arm. Resident sta	ted he was lying on couch				100
	larium when resident [Room				
	37] approached and accused				To the second
	puzzle in the solarium.				4
	otified who then notified				
DON (director of nurs	<u> </u>				
Resident sent to ER (į		
evaluation and treatm		0			
- "6/25/2022 00:20 (1		177			
_	Name of hospital] with the				
diagnosis of closed fr	acture of distal and of left		54		

ulna, abrasion of nose, closed fracture of nasal

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATIONNUMBER: A. BUILDIN		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495203	B. WING _			C 06/29/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		OOTEGEE	
ENVOY O	* Al EVANDON A A A		- 1	900 VIRGINIA AVENUE			
ENVOYO	FALEXANDRIA, LLC			ALEXANDRIA, VA 22302		1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From page	ge 21	F6	807			
	bone, closed head injury. New order of Amoxicillin-clavulanate (Augmentin) 875-125mg take 1 tablet by mouth 2 times daily for 7 days. Resident denied pain at this time, back in his room at this time will continue to monitor."		ep open manuscum namen name				
	R44 from [Name of "Reason for Visit: Diagnoses: Closed ulna, unspecified fra encounter, closed habrasion of nose, in of nasal bone, initial Wrist Left PA (poste oblique (final result) displaced ulnar fract dislocation noted. Nare presentForeal 1. Distal ulnar fract of the wrist is recommended the ulnar fracture are distal radial fracture head without contraintracranial abnormal	nmary" dated 6/24/2022 for hospital} documented in part, Facial laceration, arm injury. fracture of distal end of left acture morphology, initial ead injury, initial encounter, itial encounter, closed fracture encounterImaging results: ro anterior) lateral and Redemonstrated mildly ture. No additional fracture or flarked vascular calcifications of momplete Left (final result) ture 2. Dedicated 4 view study ture 2. Dedicated 4 view study ture and evaluate for underlyingCT (computed tomography) st (final result) 1. No acute ality. 2. Right nasal bone we compared to the prior					
	quarterly assessmenthe resident scored assessment, indicatinate for making dadocumented no behacumented R37 retransfers, walking in locomotion on and adocumented R37 between the resident assessment	7) most recent MDS, a nt with an ARD of 4/2/2022, 15 out of 15 on the BIMS ting the resident is cognitively ily decisions. Section E naviors. Section G nquiring supervision with the room and corridors and off the unit. Section G further bing not steady but able to ff assistance with walking and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

PRINTED: 07/07/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-0391		
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE ND PLAN OF CORRECTION IDENTIFICATION NU		1 ' ' ' '			STRUCTION	(X3) DATE SURVEY COMPLETED		
		495203	B. WING				1	C	
NAME OF P	ROVIDER OR SUPPLIER			_	OTOCC	TARRESC ON OTATE TIP CORE	06/	29/2022	
	NO VIDEN ON BUT LIE!		- 1			TADDRESS, CITY, STATE, ZIP CODE			
ENVOY O	FALEXANDRIA, LLC					RGINIA AVENUE ANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From pag	e 22	F (εv.	7				
	7.0	limitation in range of motion	F (OU	'				
	in the upper or lower	extremities. Section G							
	documented R37 usi	ng a walker.			35				
		p.m., an interview was							
		in their room. R37 was	141					1	
		taff member sitting outside			e.			5	
	of the room in a chai						i.		
E.	-	ous Friday they had a fight t who lived across the half.						*	
		olice had come and the							
		vised them they were going	i		1			4	
		ner room. R37 stated that			3				
		and why they were made to						ì	
		d not allowed to go outside to			.5				
		nds because they were only							
		selves. R37 stated that the							
		m in their chest when they	i					į.	
		on and they had to fight back			i			į.	
		s. R37 stated that they were			i				
		e they were not able to walk						1	
	around the facility cu	rrently or visit with their						1	
	friends. When asked	about the other resident,	S.					1	
	R37 stated that it wa	s the resident in the room					1.0		
		he cast on the arm. R37							
		ot know why they had a cast							
		t the facility staff were						-	
		a bigger deal than it needed						1	
	to be because they v themselves.	vere just trying to defend	i						
	The progress notes fin part;	or Resident #37 documented							
	- "6/16/2022 11:00 /1	1:00 a.m.)Behavioral							
		behaviors (screaming,							
		ning at Writer using foul							
		"you are an animal go back			Ì				
		n" with expletives. Slamming	201						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
			A, BUILD	ING		J COMIN		
		405000				1 9	C	
		495203	8. WING			06/	29/2022	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	-		
ENVOY O	FALEXANDRIA, LLC			900	VIRGINIA AVENUE			
	relization, LEO			AL	EXANDRIA, VA 22302			
		STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREF	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	B€	(X5) COMPLETION	
TAG	REGULATORYO	R LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE	
F 607	Continued From pa	ge 23	i F	607				
	his door"			i			i	
	- "5/4/2022 21:59 (9	9:59 p.m.) Physician progress	1				i	
		tient has been agitated,	1	- 1				
		ch (psychiatry) deemed patient		- 1	•		1	
		acity discussed with DON.					2	
		o stay in the facility as he can					-	
	be a risk to other re			1			1	
	- "5/4/2022 09:34 (9	9:34 a.m.) Note Text; slammed						
		. Resident asked if he can put		- 1			î.	
		ment cart, I said No, he	7	1				
	cannot I asked him	politely "Can you give it to me						
		the tray to me and slammed		- 1				
	the door in my face							
	- 5/3/2022 18:13 (6:	:13 p.m.) Note Text: At						
		(11:00 p.m.) on 5/2		į.				
	(5/2/2022), the ever	ning nurse notified this writer						
	that the damaged la	aptop was no longer working			19			
	after resident poure	d water on it. Writer notified					¥	
	the police who retur	ned to the facility at 0700						
	(7:00 a.m.) on 5/3 (5/3/2022) to document the						
		erty. Police stated that writer					į.	
	would have to go to	magistrate independently to						
	request the warrant	for misdemeanor destruction					1	
		officers spoke with resident in						
		writer. Resident recounted						
	the events of the pr	evious night in great detail						
		d, "what happened with the						
		Resident began stating he	3	- 1				
		ut that started to become						
		up and left the interview	:					
		are going to arrest me then	1					
		ather go to jail than be in the	1					
		currently in room alone with		1				
		pervision to ensure safety of		7				
		Resident's guardian and		- 1				
	physician updated of			1				
		0:04 p.m.) Note Text: This		1				
		call from the nurse on	3	i			1	
	resident's unit at ap	proximately 8:45pm. Nurse	9					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES		MEDICAID SERVICES			OMB NO	OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY		
		495203	B. WING		i	C /29/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		29/2022		
	2			900 VIRGINIA AVENUE	211 0000			
ENVOY O	FALEXANDRIA, LLC			ALEXANDRIA, VA 22302				
						, <u>.</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE DO TO THE APPROPRIATE DIENCY)	(X8) COMPLETION DATE		
F 607	Continued From pag	e 24		607		,		
	· -	it was upset about pain		007				
		ministered every 6 hours	ļ					
	instead of every 2 ho			<u>:</u>				
		riter could hear resident	İ					
		ound loudly and calling the		i				
		is. Nurse reported that	į					
		ng doors, yelling loudly and	ŀ					
		ne off of the wall. The nurse		1		1		
		ried to pull the door shut	<u> </u>			:		
		to enter to attend to [R37]'s	İ	t di				
		to enter to attend to [R37]s		i i				
		l over the ice pitcher on the		82		1		
		naging the medication laptop.				:		
		and they responded to the	ļ	1		1		
		e with police officers on site		1				
		re is not much we can do in	į					
	this setting other than			2.2		3		
		ficer reported that resident	1			1		
		arrival and denied doing	•					
		dication cart. Police officer	1	!		i		
		nained "on" and working, but	į			į		
		working to call back to	•					
		ge. Increased supervision	i	1		1		
		ertified nursing assistants)	1	4		1		
		of the shift. Writer left		1				
		t's guardian and physician				1		
		or. Writer also notified psych	1	4		ŀ		
		ated he would come in the	i					
	morning to see the re							
	The geriatric psychia	try consult note dated	9					
		ocumented in part, "asked				1		
		. Pt (patient) is alert &		:,5		4		
		nted. He admits he is easily						
		staff "don't care." He can be						
		ally. Has been known to use		4	53			
	racial slurs, hard to d					N.		
						3		
	The geriatric psychia	try consult note dated				Į.		
		,						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTO		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		495203	B. WING_			C 08/29/2022	
	ROVIDER OR SUPPLIER			900 VI	ET ADDRESS, CITY, STATE, ZIP CODE IRGINIA AVENUE KANDRIA, VA 22302	00/29/20	122
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	((PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO	(X5) MPLETION DATE
F 607	Continued From pag	ne 25	E 6	607			
	1		- K	,07			
		cumented in part, "Pt has					
		is frustrated he is here. Feels					
		Last week was physically		- 1			
		abbreviation for "with"]		- 1			
	behaviors that includ	ded breaking a laptop"		đ		1	
	The comprehensive	care plan for R37		1			
		"[Name of R37] is at risk for		4			
		hysical aggression, refusal of		14		- 1	
		related to) diagnosis of		ai.		i	
		with disturbance of conduct,				4	
	-	chosis and major depression.		- 4		i	
	Date Initiated: 08/16	,				1	
	11/08/2021."	72021. Nevision on.				4	
	11/00/2021,						
	The FRI (facility repo	orted incident) dated				*	
		ted in part, "[Name of R44]	110	ż		9	
		sident altercation that took		1		1	
		floor solarium between	1	6		1	
	· · ·	of R37]. Head-to-toes	1			1	
		ted, [Name of R44] presented	1			j	
		d a bruise to the back of his		87			
		/] sustained no injury. [Name				7	
		to the hospital for further	4				
		sible party and Physician	97				
		end [sic] back to their room	10.0	1			
		on, one resident send to ED		ni.			
		nent) for further evaluation,		7.4			
		initiated including resident	12	1		3	
		ws, staff interviews and staff		19			
	education"	45, Stall litter views and Stall	100				
	Jacobion		15				
	On 6/28/2022 at 114	05 a.m., an interview was				49	
		I (other staff member) #10,	-	0.		:	
		services. OSM#10 stated					
		the facility on 6/24/2022					
		had the altercation. OSM #10					
		e called and made aware of					
	*	e called and made aware or and had followed up with	25	1			
	THE INCIDENT THAT CAV	raun gan jollowen Un With		1.0			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY
			A. BUILDII				С
		495203	B. WING				06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		00:20:2022
				900 VII	RGINIA AVENUE		
ENVOY O	FALEXANDRIA, LLC			ALEX	ANDRIA, VA 22302		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG	(EACH DEFICIE REGULATORY	PREFI TAG	×	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLÉTION	
F 607	Continued From p	age 26	F	607			\$5
	100	6/27/2022. OSM #10 stated	7				
	1	lous behaviors of slamming					
	· ·	of facility property and being					
		staff members but had not		- 1			
		ression towards another		1			
		were aware of prior to that day.		1			
		hat they had been attempting to		- 1			7
		sing for R37 since they had		1			
	been to court and	deemed competent but had not					\$
	been able to find a	a safe discharge location for					1
	them. OSM #10 s	tated that R37 was alert and	1				1
	oriented and had s	stated that R44 had hit them in	i i				1
		n they had interviewed them on	1	10			V.
		ng the incident. OSM #10		9			1
		ident between R44 and R37	4				
		by any staff or other residents.		20			I.
		hat since 6/24/2022, R37 had		1			1
		nitoring and staff were with	1				\$
		e room for anything. OSM #10	1	1			Ţ.
		ad never displayed any	1				1
		s always a quiet person who					
		he Solarium watching	1				
	television.		İ				
	On 6/20/2022 at 1	2:54 p.m. on Intendeu wee					
		2:54 p.m., an interview was PN (licensed practical nurse) #7.					
		it R37 had anger issues and					
	A. Contract of the contract of	s at staff when they became				100	10
	100	ated that there were times when					1
		asant and charming to the staff.					
	No.	at they were not aware of any	i				i .
		R37 towards another resident	1	1			i i
		ition with R44 on 6/24/2022.		- 8			
	•	it they had kept R37 in their					1
		nonitoring and a chaperone if					1
		since the altercation on	1				
		7 stated that R44 had never		1			
		ressive behaviors and was					19
		l and friendly. LPN #7 stated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495203	B. WING		C 06/29/2022
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	00/23/2022
ENVOY O	FALEXANDRIA, LLC		I	'IRGINIA AVENUE XANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 607	Continued From page	27	F 607		
	· -		1 007		
		sident altercation was	1		00
	intervened upon and		1		7
		immediately reported to the administrator. LPN #7			
		and R44 were alert and			
		and R44 were alert and ace, time and situation.	1		1
	onented to person, pr	ace, une and situation.	1		
		p.m., an interview was			
		#1, unit manager. LPN #1			
		l lash out at staff at times			
		ng on eggshells." LPN #1			
		estroyed a facility laptop			
		N#1 stated that they had to			
		out of the way when R37	j		
		. LPN #1 stated that they			
	were not aware of an		į		
	PO	1/2022 with R37. LPN #1	1		
	•	y had verbal behaviors that	1		
		#1 stated that they had not	1		
	had any conversation				
	incident on 6/24/2022	LPN #1 stated that R44			
	had no history of any	behaviors and was always			
	pleasant.				
	On 6/28/2022 at 2:11	p.m., an interview was	i		
	conducted with ASM	(administrative staff			
		ctor of nursing. ASM #2			
	stated that R37 was	competent and had been to	1		
	court to have the gua	rdianship lifted. ASM #2			
	stated that R37 had p	reviously damaged a facility			
	laptop when the nurs	e would not give them	()		
	additional paln medic	ations. ASM #2 stated that			
	the police had come	at that time and R37 had lied	- 1		
	to the police saying the	ney did not remember			
	anything. ASM #2 sta	ated that R37 did not lack			
	capacity and the police	e knew they were lying but			(12)
		. ASM #2 stated that the	==		
	previous DON (direct	or of nursing) had moved	i		1
		and placed them on 1 to 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495203	B. WING		0	C 6/29/2022		
	PROVIDER OR SUPPLIER PFALEXANDRIA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE		
F 607	monitoring at that time further behaviors. A ended the 1 to 1 more because R37 was not and the physician hallifted. ASM #2 stated physician fax over a #2 stated that they for 6/24/2022 after at the day before approximate R44 had been he to the hospital. ASM arrived R44 had already was in their root spoke with R37 that because R44 touche stated that R37 had were told they were monitoring and going ASM #2 stated that they saw bruise on the neck, be #2 stated that they a call for help on 6/24/2 ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble. ASM #2 stated that R44 woul R37 because they ditrouble.	ne and there had been no SM #2 stated that they had hitoring around 5/24/2022 at displaying any behaviors didetermined that it could be dithat they were having the mote documenting this. ASM bit that R37 waited until late dministrative staff had left for aching R44 in the solarium. In 6/24/2022 after 8:00 p.m., he call from the facility saying it with a cane and was going at 2 stated that when they ady left for the hospital and m. ASM #2 stated that they hight they said they did it did their puzzle. ASM #2 coused me out when they going to have the 1 to 1 ground to another room. They left the facility prior to m the hospital. ASM #2 R44 on 6/27/2022 with the proken nose and arm. ASM sked R44 why they did not 2022 and what happened. R44 explained that R37 if up their puzzle. ASM #2 did not press charges against did not want them to get into the that R37's actions were	F 60	7				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		495203	B. WING			C 06/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC		9009	EET ADDRESS, CITY, STATE, ZIP CODE VIRGINIA AVENUE EXANDRIA, VA 22302	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	of the evening shift the station when R44 car with blood on their not them with a cane. Clitold them that R37 has up their puzzle. CNA called 911 to send R4 and they had made a sand monitored 1 on 1 were no staff or residincident. CNA #9 stated own in the solarium television. CNA #9 stated times. CNA #9 stated incident altercation with mediately separate for help. CNA #9 stated incidents to the nurse	ney were at the nurses me up to the nurses station use and said that R37 had hit NA#9 stated that R44 had ad accused them of messing u#9 stated that the nurse had to the emergency room ure R37 was in their room . CNA#9 stated that there ents who witnessed the ted that R44 normally sat every day watching tated that R37 was verbally les and had slammed doors uted that if a resident to	F 607			
	conducted with ASM stated that they care when R37 gets emoti dangerous and verba #5 stated that normal ASM #5 stated that F property but they did someone a concussi had not seen R37 sir with R44 but based of them they felt that ev ASM #5 stated that they wanted this and R37 needed to b #5 stated that they had they ha	#8 a.m., an interview was #5, medical doctor. ASM #5 for R37. ASM #5 stated that ional they could become ally difficult and act out. ASM lly R37 was not dangerous. R37 had destroyed some not feel that they could give on. ASM #5 stated that they nee the incident on 6/24/2022 on what was going on with erything was behavioral. hey felt that if R37 did not get ngs would keep happening be safely discharged. ASM and recommended for the 1 ontinue and for nursing to				

A98293 B. WING COPPROVIDER OR SUPPLIER ENVOY OF A LEXANDRIA, LLC DIVIDIO AVAINATION OF A LEXANDRIA, LLC DIVIDIO AVAINATION OF A LEXANDRIA, LLC DIVIDIO AVAINATION OF A LEXANDRIA AVA 22302 PRIEFIX (CAMO INSPICIAL STATE BE PRECEDED BY FULL REGISTRATION OF A LEXANDRIA, VA 22302 F 607 Continued From page 30 Keep working on a safe discharge. ASM #5 stated that they foll that R37 did not like F44 for some reason and vas mad at them. The facility policy "Abuse, Negloct, Exploitation & Milsappropriation" with a revision date of 11/28/2017 documented in part, "It is hisheren in the nature and dignity of each resident at the center that helds he be inforted basis human rights, including the right to be froe from abuse, neglect, mistreatment cystoliation and/or misappropriation of property. Abuse is the willful infliction of injury, unreasonable continement, intimidation, or punishment with resulting physical harm, psin, or mental anguish. Furthermore, the Administration of The Company recognizes that resident abuse can be committed by other residents, visitors, or youlkness." The policy further documented, "The conter is committed to the prevention of abuse, neglect, missappropriation of resident property, and exploitation. The following systems have been implemented:Monitoring of residents who are at risk or vulnerable for abuse, for indications of obuse, or of changes in behavior, changes in condition or other non-verbal indication of abuse On 6/28/2022 at 5:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit. Reference: 1. Julia	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ENVOY OF ALEXANDRIA, LLC ID(A) ID			495203	B. WING		_
FREENT TAG FREDULATORY OR LOS DENTIFYING INFORMATION) FROM FREDULATORY OR LOS DENTIFYING INFORMATION) FREDULATORY OR LOS DENTIFYING INFORMATION) FREDULATORY OR LOS DENTIFYING INFORMATION) FREDULATORY OR LOS DENTIFYING INFORMATION) FREDULATORY OR LOS DENTIFYING INFORMATION) FREDULATORY OR LOS DENTIFYING INFORMATION) FREDULATORY OR LOS DENTIFYING INFORMATION THAT THE CROSS-REFLERENCED TO THE APPROPRIATE CROSS-REFLERENCED TO THE APPROPRIATE FREDULATORY OR LOS DENTIFYING INFORMATION THAT THE CROSS-REFLERENCED TO THE APPROPRIATE FREDULATORY OR LOS DENTIFYING INFORMATION THAT THE CROSS-REFLERENCED TO THE APPROPRIATE FREDULATORY OR LOS DENTIFYING INFORMATION THAT THE CROSS-REFLERENCED TO THE APPROPRIATE FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFYING INC. FREDULATORY OR LOS DENTIFY INC.				90	0 VIRGINIA AVENUE	00/20/2022
keep working on a safe discharge. ASM #5 stated that they felt that R37 did not like R44 for some reason and was mad at them. The facility policy "Abuse, Neglect, Exploitation & Misappropriation" with a revision date of 11/28/2017 documented in part, "It is inherent in the nature and dignity of each resident at the center that the/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punlshment with resulting physical harm, pain, or mental anguish Furthermore, the Administration of The Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers" The policy further documented, "The conter is committed to the prevention of abuse, neglect, misappropriation of resident property, and exploitation. The following systems have been implemented:Monitoring of residents who may be at risk is the responsibility of all facility staff. This includes monitoring residents who are at risk or vulnerable for abuse, for indications of changes in behavior, changes in condition or other non-verbal indication of abuse" On 6/28/2022 at 5:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
	F 607	keep working on a sa stated that they felt the some reason and water and dignity and the nature and dignity center that he/she be rights, including the meglect, mistreatment misappropriation of profiction of injury, unrintimidation, or punish harm, pain, or menta administration of The resident abuse can be residents, visitors, or further documented, to the prevention of a misappropriation. The foll implemented: Monibe at risk is the responsation or vulnerable for abust changes in behavior, other non-verbal indicates the director of nut the concern. No further information	afe discharge. ASM #5 hat R37 did not like R44 for is mad at them. Duse, Neglect, Exploitation & the a revision date of sted in part, "It is inherent in y of each resident at the a afforded basic human ight to be free from abuse, it, exploitation and/or propertyAbuse is the willful easonable confinement, hment with resulting physical I anguishFurthermore, the e Company recognizes that the committed by other volunteers" The policy "The center is committed abuse, neglect, esident property, and owing systems have been itoring of residents who may consibility of all facility staff. Fing residents who are at risk se, for indications of changes in condition or cation of abuse" D.p.m., ASM (administrative a executive director and ASM resing were made aware of	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED
		495203	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC		9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 VIRGINIA AVENUE NEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIED OF THE APPROPROPRIED OF THE APPROPRIED	BE COMPLETION
F 607	in your arm: the hum information was obta	e 31 your body, three of them are erus, radius, and ulna. this ined from the website: ov/arminjurlesanddisorders.h	F 607		
	Reporting of Alleged CFR(s): 483.12(c)(1) §483.12(c) In respont neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, negmistreatment, includ source and misapproare reported immedia hours after the allegated that cause the allegated serious bodily injury, the events that cause and do not rest the administrator of tofficials (including to adult protective servitor jurisdiction in long accordance with Starprocedures.	se to allegations of abuse, or mistreatment, the facility at that all alleged violations lect, exploitation or ing injuries of unknown opriation of resident property, ately, but not later than 2 ation is made, if the events ation involve abuse or result in or not later than 24 hours if a the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and the state Survey Agency and the sult in care facilities) in the law through established		1. Abuse and Neglect reporting timere reviewed with the Director of to ensure all incident are reported timely manner. 2. All residents are at risk to be imby the alleged deficient practice. A quality review was conducted by Regional Director/designee to ide other regulatory guideline that neaddress in order to maintain substcompliance. 3. Regional Director of Nursing with the Director of Nursing on regulating guideline for reporting abuse and to the appropriate state agencies timely manner. 4. Regional Director of Nursing/dewill monitor the timely reporting directors to the appropriate state weekly for 4 weeks them monthly months. Findings to be reported to QAPI committee for further	of Nursing I on a pacted y the ntify any eds to be tantial Il educate ory neglect on a esignee of agencies y for 3
	designated represen accordance with Star Survey Agency, with Incident, and if the al appropriate correctiv	administrator or his or her tative and to other officials in te law, including to the State in 5 working days of the leged violation is verified re action must be taken. This not met as evidenced		recommendations.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
						С		
		495203	B. WING			06/2	29/2022	
NAME OF PE	ROVIDER OR SUPPLIER			STRE	ETADDRESS, CITY, STATE, ZIP CODE			
ENVOYO	FALEXANDRIA, LLC			900 V	/IRGINIA AVENUE			
ENVOIO	ALEXANDRIA, LLC			ALE	XANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x }	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(XS) COMPLETION DATE	
F 609	Continued From pag	e 32	F	309				
	Based on resident in	iterview, staff interview,				4		
		iew and clinical record review						
	•	at the facility staff failed to						
		irvey Agency timely, an	1	15				
	•	or one of 39 residents in the		- 6				
		dent #44; which required an		1				
		t where they were diagnosed	i	100				
		of the distal end of the left		- 1				
	ulna (1), closed head	linjury, abrasion of the nose						
	and a closed fracture	of the nasal bone.	(40)					
	The findings include:					57		
	Resident #44's (R44	most recent MDS		i				
		an annual assessment with						
		t reference date) of 5/1/2022,		- 1				
	•	5 out of 15 on the BIMS						
		ental status) assessment,		1				
		nt is cognitively intact for		1				
		ns. Section E documented	ł	- 1				
	no behaviors.			- 1				
	On 6/27/2022 at 5:14	p.m., an interview was		-				
		in their room. R44 was		i				
		l and was observed to have		1				
		an elastic bandage on the		- 6				
		sked about the splint on the						
		ed that they were hit by		i i				
		a cane in the solarium at						
	the end of the hallwa	y the previous Friday. R44						
		a fracture in the arm and a						
	fractured nose from	the incident. R44 stated that		1			10	
		emergency room and they					(ii	
		plied the splint and advised					E.	
		h an orthopedic physician to	10	- 31				
		urgery or not. When asked						
		ho hit them, R44 indicated		- 5				
		37) had approached them in	80	j.				
	the solarium and sta	rted hitting them with a cane		3				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		TE SURVEY MPLETED	
		·	A. BUILDII	NG	= = = = = = = = = = = = = = = = = = = =			
		495203	B. WING				C 06/29/2022	
NAME OF PE	OVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		012012022	
E10/03/ 0				900 VIF	RGINIA AVENUE			
ENVOYO	FALEXANDRIA, LLC			ALEX	ANDRIA, VA 22302			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	10	20	PROVIDER'S PLAN OF CORRECT	TION	: (X6)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	COMPLETION DATE	
F 609	Continued From pa	age 33	F	309			Ti.	
	over "nothing" and	they were "crazy." R44 stated		4			[
		keeping R37 in their room and		÷				
		m all the time after the incident.	ļ	†				
	_							
	The progress notes in part,	s for Resident #44 documented					G.	
		(8:19 p.m.) Note Text:					4	
		espiratory distress noted.		100				
	Resident came to	nurses station with blood on his	į				i	
	shirt and nose, bru	ises and bump (swelling)		4			1	
	behind left ear, res	ident c/o (complains of) pain of		:			į	
	left arm. Resident	stated he was lying on couch					i	
	watching TV in the	solarium when resident [Room	!				1	
	number identifying	R37] approached and accused						
3	him of messing up	his puzzle in the solarium.	i					
	Nursing supervisor	r notified who then notified						
		ursing) and called 911.					ii.	
	Resident sent to E	R (emergency room) for	5					
	evaluation and trea		il.	18			1	
		(12:20 a.m.) Note Text:		1			i	
0		n [Name of hospital] with the					9	
1		fracture of distal end of left	6	- 4			03	
		ose, closed fracture of nasal	- 8				<u> </u>	
		injury. New order of						
		nate (Augmentin) 875-125mg						
		outh 2 times daily for 7 days.						
		ain at this time, back in his		81				
	room at this time w	vill continue to monitor."		- 2				
	The "After Vielt Su	mmary" dated 6/24/2022 for	1					
		f hospital] documented in part,						
		: Facial laceration, arm injury.						
		fracture of distal end of left]				
	-	racture morphology, initial	***					
		head injury, initial encounter,		1				
		nitial encounter, closed fracture						
		al encounterlmaging results:		2				
9		ero anterior) lateral and		15				
		t) Redemonstrated mildly						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495203	B. WING	-			C	
NAME OF P	ROVIDER OR SUPPLIER	400200		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 06	/29/2022	
	FALEXANDRIA, LLC			900 VIRGINIA AVENUE ALEXANDRIA, VA 22302				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 609	: Continued From pag	e 34	F	609				
	displaced ulnar fracti	ure. No additional fracture or		i			1	
		farked vascular calcifications		1			i	
		n complete Left (final result)		į			7 8	
		re 2. Dedicated 4 view study					2	
		mended to better evaluate		- !			¥.	
		d evaluate for underlying						
		CT (computed tomography)		1				
		st (final result) 1. No acute		- 1				
		lity. 2. Right nasal bone	14					
		v compared to the prior						
	exam"		1				9	
	Posident #27's (D27) most recent MDS, a	1					
		nt with an ARD of 4/2/2022,		1				
	•	15 out of 15 on the BIMS	1	2				
		ng the resident is cognitively	i	34			22	
		ly decisions. Section E	1	-				
	documented no beha	-	1					
				1				
		6 p.m., an interview was					35	
		in their room. R37 was	i i					
		staff member sitting outside					92	
		r monitoring the room. R37					3.4	
		ous Friday they had a fight	i i				×	
	A. Contract of the contract of	t who lived across the hall. colice had come and the		4				
		vised them they were going						
		ner room. R37 stated that					1	
		and why they were made to						
	-	d not allowed to go outside to						
		nds because they were only						
	trying to defend then	nselves. R37 stated that the		1				
		m in their chest when they		3				
	· ·	on and they had to fight back						
		s. R37 stated that they were		į				
		se they were not able to walk						
		rrently or visit with their						
		d about the other resident,	3					
	K3/ stated that it wa	s the resident in the room	7	1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY APLETED
			1 2 2 3 3 3 3 3 3			С
		495203	B. WING		0	8/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 609	stated that they did n now. R37 stated that making the fight into to be because they w themselves.	ne cast on the arm. R37 ot know why they had a cast the facility staff were a bigger deal than it needed ere just trying to defend	F 609			
	in part: - "6/28/2022 13:46 (1 Addendum- On 6/24/ number identifying Rowith blood on his nos (swelling) behind his blood on his shirt. Reidentifying R44] c/o p number identifying Roon the couch watchin above resident [Room approached and accupuzzle in the solarium R44] stated he did not puzzle. Then [Room struck [Room numbe walking cane repeate identifying R44] state cover and protect his identifying R37] then number identifying Roreported writer. Write who then reported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Resident [Room number identifying Roreported to Roman Indiana [Roman Indiana [Room number identifying Roreported to Roman Indiana [Room number identifying Roreported Indiana [Room number identifying Roreported Indiana [Room number identifying Roreported Indiana [Room number identifying Roreported Indiana [Room number identifying Roreported Indiana [Room number identifying Roreported Indiana [Room number identifying Roreported Indiana [Room number identifying Roreported Indiana [Room number identifying Roreported Indiana [Room number identifying Roreported Indiana [Room number identifying Room number identifying Roreported Indiana [Room number identifying Room number identifying Room number identifying Room number identifying Room number identifying Room number identifying Room number iden	2022 resident [Room 44] came to nurses station e, bruises and bump left ear. There was also sident [Room number ain on left hand. [Room 44] stated that he was lying ig TV in the solarium when in number identifying R37] used him of messing up his in. [Room number identifying of know anything about his number identifying R37] r identifying R44] with his indidy. [Room number id he used his left arm to face. [Room number hit his arm too. [Room 44] ran to nurses station in called nursing supervisor DON and called 911. iber identifying R44] was pital] ER (emergency room)				
	[Name of Facility], Re	rted incident) dated ed in part, "Facility Name: eport Date: 06/25/2022, 2022" The FRI further				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED			
		495203	B. WING			C 06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	
ENVOY O	FALEXANDRIA, LLC				RGINIA AVENUE	
				ALEX	ANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFL TAG	× !	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 609	Continued From pag	je 36	F	309		
	documented, "[Nar	me of R441 reported				
		ercation that took place in the				
		m between himself and				
		d-to-toes assessment				İ
	11.5	f R44] presented with nose		ě.		
		o the back of his neck.				
		ined no injury. [Name of	3	1		
		he hospital for further	1			
		sible party and Physician	3			
	notified. Resident se	end [sic] back to their room	4			*
	under 1:1 observation	n, one resident send to ED				
	(emergency departm	nent) for further evaluation,	1			
	facility investigation i	initiated including resident				
	evaluations/interviev	vs, staff interviews and staff	3			
		tached fax confirmation		į		
	1	tion to the state agency on	1			
	6/25/2022 at 16:37 (4:37 p.m.).				
		1 p.m., an interview was				
		l (administrative staff		i		
		ector of nursing. ASM #2	3			
	45	2022 after 8:00 p.m., they		1		
		Il from the facility saying that		1		
		th a cane and was going to		i i		3
	- ·	2 stated that when they		1		
		, R44 had already left for the				
		s in their room. ASM #2				
	· · · · · · · · · · · · · · · · · · ·	the facility prior to R44		1		
		e hospital. ASM #2 stated				
	The second secon	back to the facility on	- 2			
	The second secon	ne FRI to the state agency.	1.00	1		
		they had come to the facility		- 1		
	7	se they thought that they had		Ŧ.		į
		o report the incident and they	124	T		1
	P. Contract of the Contract of	window. ASM #2 stated that		1		1
		heir policy and talked with a	4	1		1
		ho advised them that they rs to send the report. ASM		T		1
		they came in on 6/24/2022	S.			
	ιπ∠ οιαισά triat WillOff	trioy carrie in on 0/24/2022	25.7			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495203	B. WING				(
NAME OF PI	ROVIDER OR SUPPLIER	400200		STREET	ADDRESS, CITY, STATE, ZIP CODE	ļ	06/2	29/2022
ENVOY O	FALEXANDRIA, LLC			900 VIR	GINIA AVENUE NDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1.0	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 609	they knew that R37 h bodlly injury requiring emergency room so o ball" on sending the r timeframe. The facility policy "Re Suspicion of a Crime 11/28/2017 document that causes the reast serious bodlly injury, immediately after for later than 2 hours after Otherwise, the report than 24 hours after for Where an alleged vio misappropriation of r exploitation also give suspicion of a crime, Administrator, to the local law enforcement Reporting, Serious B the event that caused results in serious bod covered individual sh immediately, but not forming the suspicion On 6/28/2022 at 5:30 staff member) #1, the	and hit R44 and caused by them to have to go to the shey may have "dropped the report in the two hour apporting Reasonable "with a revision date of sted in part, "If the event conable suspicion results in the report must be made ming the suspicion (but not er forming the suspicion). It must be made not later forming the suspicion. 3. In the suspicion of abuse, neglect, resident property, or so rise to a reasonable reports will be made to the State Survey Agency, and to st Time period for Individual codily Injury- 2 hour limit: If the the reasonable suspicion later than 2 hours after	F	609				
		n was provided prior to exit.						
	Reference:							
	1. ulna Of the 206 bones in y	your body, three of them are		Miles and the same				e :

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:				SURVEY
			7. 501251			С
		495203	B. WING		06	/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 609	information was obta https://medlineplus.g tml	nerus, radius, and ulna. this ained from the website: gov/arminjuriesanddisorders.h	F	609		8/2/2022
F637 SS≈D	CFR(s): 483.20(b)(2) §483.20(b)(2)(ii) Widelermines, or shoul there has been a signesident's physical or purpose of this section means a major declinesident's status that itself without further implementing standarinterventions, that had one area of the resident's interdisciplicate plan, or both.) This REQUIREMEN by: Based on staff internand clinical record rethe facility staff failed change MDS for one sample, Resident #82 was at 12/22/21. There was completed for the promote of the findings included the most recent quarterly assessment Reference Date) of the sident of the process of the formal clinical record rether the findings included the most recent quarterly assessment reference Date) of the most recent reference Date of the process of the formal clinical record rether the process of the most recent quarterly assessment reference Date) of the most recent reference Date of the process of the formal clinical record rether the process of the formal clinical record rether the process of the formal clinical record rether the process of the formal clinical record rether the process of the formal clinical record rether the formal clinical recor	thin 14 days after the facility ld have determined, that unificant change in the profession of the pro		1. Resident #82 was observed missed a significant change I December of 2021. RN #1 was about ensuring Significant Clacompleted per the RAI. 2. All residents who require his services are at risk to be impalleged deficient practice. A was completed to determine had a change of condition the significant change Minimum addressing hospice. 3. Director of Clinical Services Minimum Data Set Coordinal significant change Minimum requirements per the RAI in a hospice services. Director of Nursing, or design Unit Managers regarding repichanges in hospice services Minimum Data Set Coordinal Clinical Morning Meeting to its significant changes. 4. Director of Clinical Services Managers to conduct Quality Review weekly for 4 weeks to 2 months to ensure residents in hospice services have a Significant changes. Change Minimum Data Set sand per the RAI. The Director Services will reporting finding Committee and Quality Moniwill be modified based on fin	MDS in as educated nange MDS is cospice acted by the quality review if any residents at required a Data Set cors regarding Data Set cogards to come, to educate corting all to the tor during dentify as/Unit Monitoring hen monthly for with a change ignificant submitted timely or of Clinical gs to the QAPI toring schedule	r

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILD			С
		495203	B. WING	<u> </u>	-	06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	0/20/2022
ENVOY O	FALEXANDRIA, LLC			1.00	IRGINIA AVENUE	
	·			ALEX	(ANDRIA, VA 22302	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE COMPLETION
F 637	Continued From pa	nge 39	F	637		
	Interview for Menta	I Status) indicating the				18
		tively intact in ability to make	i			4
		The resident was coded as		- 1		1
		on for eating and extensive to		1		75
	total care for all oth	er areas of activities of daily		1		
	living.			1		514
	A manda of Manager					
		ical record revealed a		- 1		İ
	again on 4/1/22 for	ated 12/22/21 and rewritten		- 1		3
	again 011 4/ 1/22 101	Hospice services.		1		
	Further review of th	ne clinical record revealed a		1		
		12/22/21 that documented.		1		1
		into [name of] Hospice, with		1		
		ongestive heart failure) and				
	COPD (chronic obs	structive pulmonary disease)"		1		
	A review of the abo	ve MDS for Section O "Special		i		
		dures, and Programs" revealed		ĺ		
		ing coded for hospice. The				
		as also a quarterly MDS,				4
	dated 3/8/22 and a	so coded the resident as				
		However, further review of the				
		at the most recent significant		İ		
		dated 12/6/21, before the		ļ		
		ed hospice services. The				
		oded on this MDS as being on		ĺ		
		re no significant change				
		o reflect the significant change ed to hospice services, in		į		
		ther the 12/22/21 hospice order				
	or 4/1/22 hospice of					
			62.	4		
	On 6/29/22 at 9:30	AM, an interview was				10
	conducted with RN	#1 (Registered Nurse) the		92		.0
		tated that when a resident				
		spice services, a significant				10
		o be done. She reviewed the		-		
	clinical record and	verified that it was not done.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G			
		Ancana	D MINO			С	
		495203	B. WING _			06/29/2022	
NAME OF P	ROVIDER OR SUPPLIER		Į.	STREET ADDRESS, CIT			
ENVOY O	FALEXANDRIA, LLQ		- 1	900 VIRGINIA AVENU	E		
	, , , , , , , , , , , , , , , , , , , ,		- 1	ALEXANDRIA, VA	22302		
(X4) ID PREFIX TAG	(EACH DEFICE	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIA DEFICIENCY)		
F 637	Continued From p	page 40	Fe	37		8	
	When asked abou	ut policies for completing the	1				
		the facility uses the RAI Manual.	3			5:	
		•				5	
	A review of the R	Al Manual (Resident	3	İ		+	
		rument) Version 1.17.1 dated	- 3				
	October 2019, do	cumented as follows:	1	!			
			i	į			
		ssessment Management	i	i			
		d Tips for Significant Change in		1			
		onts" and continued on page					
		ented, "An SCSA is required to en a terminally ill resident enrolls	1			į	
	•	ram (Medicare-certified or	1				
		ospice provider) or changes	i			N.	
		s and remains a resident at the	1				
		ne ARD must be within 14 days				20	
		date of the hospice election	1			31	
		same or later than the date of				1	
	the hospice electi	ion statement, but not earlier					
	than). An SCSA r	must be performed regardless of		1		.8	
		ssment was recently conducted		i		1	
		his is to ensure a coordinated				8	
		een the hospice and nursing				û.	
	home is in place						
	0 0 E	- d		Ì		1	
		s documented, "O0100: Special				10	
		edures, and Programs: care - Code residents identified				1	
		pice program for terminally ill		#		d.	
		n array of services is provided	1	1		4	
		and management of terminal				15	
		d conditions. The hospice must					
		e state as a hospice provider					
		nder the Medicare program as a	1.			1	
	hospice provider.						
		proximately 1:00 PM, ASM #1		1			
		taff Member) the Executive		i			
	Director, ASM #2	the Director of Nursing, and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495203	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	00/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	Services, were mad further information v survey.	al Director of Clinical e aware of the findings. No was provided by the end of the	F 63		
	Accuracy of Assessic CFR(s): 483.20(g) §483.20(g) Accuracy The assessment muresident's status. This REQUIREMENT by: Based on staff interfacility document review, it was determined to a sample, Resident #5. The facility staff failed annual assessment. The findings included Resident #90 was a 9/6/19 with diagnose limited to: paranold nicotine/cigarette dealson mulain galt. Resident #90's most assessment, with an of 3/29/22, coded the of 15 on the BIMS (I status) score, indicating the same status) score, indicating the same status is the same status.	y of Assessments. Ist accurately reflect the IT is not met as evidenced view, resident Interview, view and clinical record mined the facility staff failed to te MDS (minimum data set) of 39 residents in the survey 30. ed to complete an accurate MDS for Resident #90. c: dmitted to the facility on es that included but not schizophrenia, ependence, arthritis and t recent MDS, an annual n assessment reference date e resident as scoring 15 out orief interview for mental uting the resident was IDS Section J1300- coded the	F 64	1. Resident #90's Annual Minimum Set with Assessment Reference Da 3/29/22 was modified on 7/10/22 to current smoking status in Section O RN #1 was educated to ensure residents who is accurately coded MDS. 2. A quality review of residents who is active smokers was conducted on 7 to ensure smoking status was accurated on the most recent Comprehe Minimum Data Set. Follow up base finding. 3. Director of Nursing, or designee, educate Minimum Data Set Coordinates accurately coded on their Minimum Set. Unit Managers will be educated to resident meeting of any change in resident smoking status is accurately coded on their Minimum Set. Unit Managers will be educated to resident meeting of any change in residential meeting of any change in residential meeting of any change in residential meeting of any change in residential meeting of any change in residential meeting of any change in residents who smoke weekly for 4 withen monthly for 2 months to ensure Section O of their Minimum Data	te of reflect . dent's on the are /10/22 rately ensive d on to pators to Data notify the the daily sident ata Set s, to of veeks et is Clinical e QAPI

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER;	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495203	B. WING			C 06/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, C 900 VIRGINIA AVENU ALEXANDRIA, VA		00/29/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)	
F 641	A review of Resident 9/17/19 revealed the Resident is a smoke Instruct resident about and about smoking available. Instruct repolicy on smoking: Ideoncerns." A review of the smoke smoking evaluations Resident #90 on 9/1/2 and 3/3/22. A review of the smoke revealed, "Summary determined to be a son entrance a requestimes and locations at that smoke. The smallest smoke. The smallest smoke. The smallest smoke. The smallest smoke. The smallest smoke was confirmed to PM on 60 of the smoke state of the smoke state of the smoke state of the smoke smoking at stated, I have been smoking at	t #90's care plan dated following, "FOCUS: r. INTERVENTIONS: but smoking risks and hazards cessation aids that are esident about the facility becations, times, safety ding evaluations revealed that shad been completed for /20, 12/1/20, 3/1/21, 11/24/21 ding evaluation dated 3/3/22 of Evaluation: Resident is afe smoker." est was made for the smoking as well as a list of residents toking times listed were 0 PM, 4-4:15 PM and dent #90 was on the list. Deserved during the smoking following since I came here. Inducted on 6/27/22 at 4:00 following since I came here. Inducted on 6/29/22 at 9:25 fred nurse) #1, the MDS asked to review Resident RN #1 stated, "tobacco use that it was done by another folly what she (MDS)	F.	541		
		look at the 7 day look-backed for documentation. There		1		

00111011	O TOTTIMEDIOTALE OF	WEDIONID OF MAIOEO				CIME NO.	0830-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE S COMPL	
		495203	B. WING			06/2	9/2022
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00,1	
				(VIRGINIA AVENUE		
ENVOY O	FALEXANDRIA, LLC			l	EXANDRIA, VA 22302		
				AL	EXAMPRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page	÷43	F	641		*	
		s notes, she would have	8	V-1			
		noking evaluation, but				i	
		ecause it was outside of the				1	
-). I see it is on the care plan	19				
		is not here, she probably		i			
37		s notes. If I was coding		Ì			
		led the nurses after seeing		†			
		plan. Technically no it is not				34	
		have looked at the care				100	
G		hat the standard is for the		33		3	
		stated, "We use the RAI		1/2			
		nt Instrument) manual."		14			
. 1	0.00000			1			
		PM, ASM (administrative	10	- 1		7/27	
		executive director, ASM #2,		1			
		g and ASM #3, the Regional prvices were made aware of	9.	- 1			
	the above concerns.	NAICES MEI E ITIAGE AMAIE OI					
	No further information	n was provided prior to exit.	i i				
F 655	Baseline Care Plan	Provided Prior to Comm	(i) E	655 1	. Residents #301 and #303 had their	r current (2/2/2022
	CFR(s): 483.21(a)(1)-	-(3)	20	000	omprehensive care plan reviewed w	ith them	3/3/2022
		(-)			nd were provided a copy with docum		
	§483.21 Comprehens	sive Person-Centered Care	į		the medical record. Resident #299		
	Planning				onger resides in the Center.	vi.	
	§483.21(a) Baseline	Care Plans			PN #4 was educated regarding com	nleting a	
		cility must develop and			aseline care plan upon admission a		
	implement a baseline	care plan for each resident			eviewing the care plan with the resid		
		uctions needed to provide			epresentative within 48 hours with	4	
	effective and person-	centered care of the resident		d	ocumentation in the clinical record a	ind	
9		al standards of quality care.			roviding a copy as indicated.		
	The baseline care pla				. All new residents are at risk to be i		
		in 48 hours of a resident's	1		y the alleged deficient practice. A qu		
	admission.				eview was conducted on residents a		
3		um healthcare information	**		ince 6/27/22 to ensure baseline care		
	necessary to properly		18		vas completed, provided and reviewe	ed with	
	including, but not limit				he resident representative with		
	(A) Initial goals based	d on admission orders.		U	locumentation in the clinical record.		
1				103			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	1,	E SURVEY PLETED
						С
		495203	B. WING _			/29/2022
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	CODE	
ENVOY O	FALEXANDRIA, LLC			900 VIRGINIA AVENUE		
				ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TTION SHOULD BE THEAPPROPRIATE	(X5) COMPLETION DATE
F 655	Continued From pag	e 44	F 6	55		8/3/2022
	(B) Physician orders		1	Continued From page 44		-, -, -, -,
	(C) Dietary orders.		1	3. Director of Clinical Se	rvices/Linit	
	(D) Therapy services	3.		Managers to educate Lig		
	(E) Social services.			staff on completing base	_	1
	(F) PASARR recomm	nendation, if applicable.	i	admission, providing and		
	§483.21(a)(2) The fa	willing may dayalan a	4	with the resident represe		
		plan in place of the baseline	1	scanning a signed copy i	into the medical	
	care plan if the comp		i i	record.		
	(i) Is developed with	in 48 hours of the resident's		Interdisciplinary team to admissions daily in Morn		
	admission.		175	ensure baseline care pla		i
		ements set forth in paragraph		reviewed with the reside		
		ccepting paragraph (b)(2)(i) of		within 48 hours of admis		
	this section).			documentation in the me		
	8483.21(a)(3). The fa	acility must provide the	: 0	4. Director of Clinical Se		i
		presentative with a summary		Director of Clinical Service		
		plan that includes but is not		Quality Monitoring Revie then monthly for 2 month		3
	limited to:			admissions have baselin		
	(i) The initial goals o			completed, provided and		
		e resident's medications and	1	resident representative,		ı İ
	dietary instructions. (iii) Any services and	d treatments to be		the medical record. The		
		facility and personnel acting		Services will reporting fir		
	on behalf of the facili		1	Committee and Quality N		Э
	(iv) Any updated info	rmation based on the details	i	will be modified based or	n findings.	
		e care plan, as necessary.		ļ.		
		T is not met as evidenced				
	by:	nton davis, at aff into a davis and				1
		nterview, staff interview and v, it was determined that the				1
		provide a written summary of				
		in for 3 of 39 residents in the				1
		dents #301, #303 and #299.	4			-
	The findings include:					•
		illed to provide a written		:		
	summary of Residen	t#301's (R301) baseline			Α	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495203	B. WING			06/29/202	2
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			900 V	ET ADDRESS, CITY, STATE, ZIP CODE IRGINIA AVENUE KANDRIA, VA 22302	0000000	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPI	X5) LETION '
F 655	Continued From page	ge 4 5	F:	655		i	
	care plan to the res	•		000		1	
				- 2			
	(resident's represen	nauvej.	-1-	1			
	DOO4 was admilled	4- 4- 5- 111h 400 100 . O .		22		4	
		to the facility on 4/20/22. On	1				
		S (minimum data set), an	-	1		1	
		ent with an ARD (assessment	1			3	
		/27/22, the resident scored 15	*	4		1	
	l .	AS (brief interview for mental	İ	1		i	
		ne resident is not cognitively	i				
	impaired for making	ı daily decisions.	i				
			k B			- 1	
	A review of R301's	clinical record revealed a	-			Al .	
	baseline care plan o	dated 4/20/22. Further review	İ			(3)	
	of R301's clinical re	cord (including the baseline	i	- 1			
	care plan and progr	ress notes since admission)	ļ			3	
		umentation that R301 or the				4	
		written summary of the	ŀ	4			
		or the baseline care plan.		- 1			
		•		1		3	
	On 6/28/22 at 2:30	p.m., an interview was	1	- 1			
		V (licensed practical nurse) #4.	I	- 1		6	
		urses complete baseline care		- 1	10.5	3	
		, review the care plans with	ļ	- 11		- 1	
		presentatives and have the		- 5			
		presentatives sign the care	i	- 1		i	
		ed residents/representatives		- 3			
	•	ered or provided a written	i	83		194	
		aseline care plans or their	ŀ	1			
	-	plans but the baseline care		÷			
	plans are provided i			i		ii.	
				1			
	On 6/28/22 at 4:19	p.m., an Interview was		1			
		01. The resident stated a		ļ			
		had not been provided.		ì			
				- !			
	On 6/28/22 at 5:40	p.m., ASM (administrative	1			100	
	ř.	he executive director) and		1		0	
		or of nursing) were made		=			
	aware of the above			İ			
	aware or rise and a	CONDON.		1		i i	

PRINTED: 07/07/2022 FORM APPROVED

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495203	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC		900 V	ET ADDRESS, CITY, STATE, ZIP CODE VIRGINIA AVENUE XANDRIA, VA 22302	×
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 655	Continued From pag	je 46	F 655		
	to document informa written summary or t resident and/or the F	ation regarding the baseline care plan but failed ation regarding providing a the baseline care plan to the			20 20 20 21 21 21
	admission minimum not complete. An ac	to the facility on 6/24/22. An data set assessment was dmission data collection dated d R303 was alert and oriented time.			
	baseline care plan de of R303's clinical recore plan and progrefailed to reveal documents was provided a version of the care plan and progrefailed to reveal documents.	clinical record revealed a lated 6/24/22. Further review cord (including the baseline ess notes since admission) umentation that R303 or the written summary of the or the baseline care plan.			
81	conducted with LPN LPN #4 stated the nu- plans on admission, residents or their rep residents or their rep plans. LPN #4 stated are not routinely offe summary of their base	o.m., an interview was I (licensed practical nurse) #4. urses complete baseline care review the care plans with presentatives and have the presentatives sign the care ad residents/representatives pred or provided a written useline care plans or their			

BTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		495203	B. WING_				06/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			900	REET ADDRESS, CITY, STATE, ZIP CODE VIRGINIA AVENUE EXANDRIA, VA 22302	 _	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	Continued From page	e 47	F	355			
	plans are provided if	requested.	÷	i			
3	baseline care plan ha On 6/28/22 at 5:40 p.	. The resident stated a	1				
4	ASM #2 (the director	1				79	
	aware of the above c	oncern.					
No further information		n was presented prior to exit.	4		\$ 10.		
					in the state of th		88
	the most recent MDS admission assessme reference date) of 6/2 out of 15 on the BIMS	o the facility on 6/10/22. On 6 (minimum data set), an ont with an ARD (assessment 17/22, the resident scored 15 6 (brief interview for mental e resident is not cognitively daily decisions.		A CONTRACTOR OF THE STATE OF TH			
	baseline care plan da of R299's clinical rec- care plan and progre- failed to reveal docur RR was provided a w	inical record revealed a sted 6/10/22. Further review ord (including the baseline as notes since admission) nentation that R299 or the written summary of the the baseline care plan.		1			
	LPN #4 stated the nu plans on admission,	m., an interview was (licensed practical nurse) #4. rses complete baseline care review the care plans with resentatives and have the	Mark 1 (100) - 100 (100) (100) (100) (100) (100)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495203	B. WING _		06	C /29/2022
	OVIDER OR SUPPLIER ALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	,0	A STAULZ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 657 SS=D	plans. LPN #4 stated are not routinely offer summary of their base actual baseline care plans are provided if r R299 discharged fron could not be interview On 6/28/22 at 5:40 p.s staff member) #1 (the ASM #2 (the director aware of the above converse plan Timing and CFR(s): 483.21(b)(2)(s) 483.21(b)(2) A completion of the comprehensive as (ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practite resident and the resident and the resident record if the predictal record if the pre	residents/representatives ed or provided a written eline care plans or their plans but the baseline care equested. In the facility on 6/28/22 and ed. In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the facility on 6/28/22 In the fac	F	1.Resident #82 had his care plan on 06/26/22 to reflect his current status. RN #1 was re-educated about er comprehensive care plan is updatimely manner to accurately refleresident's current status, includin services. 2. All residents on hospice servicinsk for being impacted by the all deficient practice. A quality review of hospice reside comprehensive care plans to ensaccurately reflect the resident's of status and plan of care. Follow con findings. 3. Director of Clinical Services to Minimum Data Sets Coordinators Managers, Activities, Dietary and Services about ensuring resider plans are updated in a timely malchanges and thoroughly reviewe scheduled times.	hospice asuring the ated in a ct the ag hospice ses are at eged ents' sure they current up based educate s, Unit at Social at care nner with	8/3/2022

CENTER	S FUR MEDICARE & I	VIEDICAID SERVICES			OMB N	O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION NG	1, 1,	E SURVEY APLETED
		495203	B. WING	·	0.6	C 3/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		n L 31 E V L E
				900 VIRGINIA AVENUE		
ENVOY O	FALEXANDRIA, LLC			ALEXANDRIA, VA 22302		
(VA) ID	QI MANAADV OT	ATEMENT OF DEFICIENCIES			EDECTION:	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
				Continued From pa	ıge 49	8/3/2022
F 657	Continued From page	49	j, F	657		
	resident's care plan.			Interdisciplinary team to revi		1
		staff or professionals in		changes during daily Clinica		
		ned by the resident's needs		ensure resident's care plan timely manner to reflect thei		
	or as requested by th		19	4. Director of Nursing/Assist		i i
		sed by the interdisciplinary		Nursing to conduct Quality		
		ssment, including both the		Review of 10 residents daily		S.
	comprehensive and cassessments.	uarteny review		then monthly for 2 months to		61
		Is not met as evidenced	As	changes to the plan of care		掘
	by:	13 Hot mot as avidenced		a timely and accurate mann		
4	•	iew, facility document review		of Clinical Services will repo		
		view, it was determined that		the QAPI Committee and Q		
	the facility staff falled	to review and revise the	**	schedule will be modified ba	ased on finding	3.
		plan for one of 39 residents	- 1			
	in the survey sample;	Resident #82.				
	Resident #82 was ad	mitted to hospice on	E8	1		
	12/22/21. There was		1	T.		100
	comprehensive care	plan to address the provision	10			
29	of and coordination w	ith hospice services.				
	The findings include:					
	On the most recent M	IDS (Minimum Data Set) a		1		
	quarterly assessment	with an ARD (Assessment				
		8/22, Resident #82 scored		1		
9		15 on the BIMS (Brief	l I			
	Interview for Mental S			1		
		ely intact in ability to make		i i		
		he resident was coded as				
		for eating and extensive to areas of activities of daily	1	1		
	living.	areas or activities of daily				
	A resilence of the attains	al rangual variants -	;			
	A review of the clinical					
	again on 4/1/22 for h	ed 12/22/21 and rewritten				
	Further review of the	clinical record revealed a		i.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495203	B. WING _		<u>.</u>	C 06/29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			900 V	ET ADDRESS, CITY, STATE, ZIP CODE IRGINIA AVENUE KANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 657	"Resident admitted Diagnosis: CHF (co COPD (chronic obs with NO (new order Acetaminophen (1) PO (by mouth) Q 6 The Clock." A review of the correvealed one dated for "Resident has a to) DNR (Do Not Redated 8/6/21 and re"Discuss advanced residents represent DNR." Neither this addressed end of fill and coordination with the conducted with RN MDS nurse. She sion hospice, the conducted with RN MDS nurse. She sion hospice, the conducted to addressed and in respective the completion assessment (exception and as needed. The ensure the plan of the attaining or maintain addressed and that the attaining or maintain according to the conducted with RN manufacture and as needed. The ensure the plan of the attaining or maintain addressed and that the attaining or maintain according to the conducted with RN manufacture and the completion assessment (exception assessment) and the conducted with RN manufacture and the conducted with RN m	12/22/21 that documented, into [name of] Hospice, with ingestive heart failure) and tructive pulmonary disease).	F	557			
			1			10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495203	B. WING		C 06/29/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE COMPLETION THE APPROPRIATE DATE	
	(Administrative Staf Director, ASM #2 th ASM #3 the Region Services, were made further information was survey. (1.) Hydrocodone Amedication used to Information obtained https://medlineplus.tml	ximately 1:00 PM, ASM #1 f Member) the Executive e Director of Nursing, and al Director of Clinical e aware of the findings. No vas provided by the end of the cetaminophen - an opiate treat moderate to severe pain. d from gov/druginfo/meds/a601006.h		857		
	CFR(s): 483.35(d)(7) Regular The facility must conference of every nurse aide months, and must producation based on reviews. In-service requirements of §48 This REQUIREMENT by: Based on staff intereview, it was deterfailed to ensure that nursing assistants) reviews. The findings included the annual performation of 106/28/2022 a restricted to the annual performation of 106/28/2022 a restricted to the annual performation of 106/28/2022 a restricted to the annual performation of 106/28/2022 a restricted to the annual performation of 106/28/2022 a restricted to 106/28/2022 a restricted	lar in-service education. mplete a performance review at least once every 12 rovide regular in-service the outcome of these training must comply with the i3.95(g). IT is not met as evidenced rview and employee record mined that the facility staff is of 10 CNAs (certified received annual performance		compliance with the yearl evaluations and annual convaluations and annual convaluation for the employed. All residents are at risk the alleged deficient pract A quality review was conceded to the experience of employees annual evaluation in the revaluation and review of their supervisor. Human Resources to devor employees that are durannual evaluation/review and notify the Executive Director of Clinical Services. Human Resources Conceded to the executive Director of Clinical Services. Human Resources Conceded to the executive Director of Clinical Services annual evaluation are complete introductory period and a regulations	y performance ompetency ees. to be impacted by tice. ducted by Human les to determine if are out of that were due for months of March, eceive an competencies from velop monthly list e for 90 day or of competencies Director and ees. ordinator to re-or and Department erformance ed after 90 day	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2022 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		SURVEY PLETED
		495203	B. WING_		I	C /29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		ILS/EULE
				900 VIRGINIA AVENUE		
ENVOYU	F ALEXANDRIA, LLC			ALEXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG		N SHOULD BE	(X5) COMPLETION DATE
				Continued From page 52		i i
F 730	Continued From page	÷ 52	□ F	By the 5th of each month the	. I I	1
	1. CNA # 3 - hire date 12/17/2019, no evidence of performance review between 12/17/2019 and 12/17/2020. 2. CNA # 4 - hire date 10/18/2019, no evidence of performance review between 10/18/2019 and			Resources Coordinator will evaluations due for the month the list to department heads evaluations and competence	ith and provide to ensure	8/3/2022
	10/19/2020.	w between 10/10/2019 and		and updated as indicated.		i.
		te 05/20/2019, no evidence		4. Executive Director to con		
		w between 05/20/2019 and	LÚ.	Monitoring Review of 10 em		
	05/20/2020.			weekly for 4 weeks then mo		
		e 4/27/2018, no evidence of		months to ensure performal evaluations/competencies a		
	04/27/2022.	petween 04/27/2021 and		per regulations. Identified I	ssues to be	4
		te 01/05/2017, no evidence		corrected. Findings to be re Quality Monitoring schedule		
	of performance review 01/05/2022.	orformance review between 01/05/2021 and 5/2022.		based on findings.	to be modified	
		proximately 1:05 p.m. an				
		ted with ASM (administrative	100			
	(other staff member)	rector of nursing and OSM				
		ed for the competency	15	B		
		listed above ASM # 2 stated				
		the competency reviews.				
		s responsible for completing	631			
	the competency review	ws ASM # 2 stated that the				
		responsible for completing				
		hat they knew the CNAs.	(B)			
		ibe the procedure for the				
		OSM#8 stated that the	1			
		ted annually with the CNAs	10	\$ 0 1		
	the competency revie	versary date for completing ews.	3			
		Employee j=Job Performance	10			
		cumented in part, "Policy: It Is				
		npany to evaluate each	1.0	₹:		
	i employee's job perfor l ongoing basis. Emplo	mance on a continual and byees will receive an	4			

evaluation of their performance prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495203 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		IDENTIFICATION NI IMPER:				SURVEY
				C /29/2022		
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		2012022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HEAPPROPRIATE	(X6) COMPLETION DATE
F 756	annually thereafter evaluations are to be immediate supervisor department head, or supervisor, by the de evaluations for facilit reviewed and approv Director prior to being employee. Annivers your start date is the formal review and pe unless a job change change includes a ch generally will be revie the date of the job ch change takes place, review date." On 05/29/2022 at ap # 1, executive director nursing and ASM # 4 services, were made No further informatio Drug Regimen Revie CFR(s): 483.45(c)(1) \$483.45(c) Drug Reg §483.45(c)(1) The dr must be reviewed at licensed pharmacist. §483.45(c)(2) This re of the resident's median	troductory Period and Written performance prepared by the employee's r in conjunction with the in the absence of a spartment head. All y employees must be red by the facility Executive g reviewed with the ary Date: The anniversary of date you should receive your aformance evaluation, has taken place. If a job hange in compensation, you rewed again one year from hange. If no compensation you will retain your original proximately 12:40 p.m., ASM or, ASM # 2, director of regional director of clinical reware of the findings. In was presented prior to exit. In was presen	F7	1. Pharmacy recommenda function panel for resident and resulted 6/30/2022 with intervention required. 2. All residents at risk to be alleged deficient practice. A quality review was conducted pharmacy medication recodence for the month of May 2022 to ensure all were according to the second pharmacy medication.	#62 was drawn th no further impacted by the ucted on all ommendations y and June of	8/2/2022
		narmacist must report any ttending physician and the				

CENTER	S FOR WEDICARE &	MEDICAID SEKVICES			OMB NO	<u>J. 0938-0391</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495203	B. WING_			C /2 9/2022
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		LUIZUZZ
			1	900 VIRGINIA AVENUE		
ENVOY O	FALEXANDRIA, LLC			ALEXANDRIA, VA 22302		
	O. W. MARTYOT	ATTICLE OF DELICITION				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
			4	Continued From page 54		
F 756	Continued From page	54	F 7	756		
	· =	ctor and director of nursing,		3. Executive Director/Directo	r of Clinical	8/3/2022
	and these reports mu		<u> </u>	Services to educate unit mar	nager on	6/3/2022
		de, but are not limited to, any	1	addressing pharmacy recom	•	¥
		riteria set forth in paragraph		medication review on timely		
	(d) of this section for		1	manager's email forwarded t		1
	(ii) Any irregularities r	noted by the pharmacist		representative to ensure the	•	
	during this review mu	st be documented on a	4	all resident recommendation	•	
	separate, written repo	ort that is sent to the		Assistant Director of Clinica		•
		nd the facility's medical		Managers will validate by the		:
		of nursing and lists, at a		month that all pharmacy reco		:
		nt's name, the relevant drug,		have been reviewed and add		i
		e pharmacist identified.		indicated by the medical teal		
		sician must document in the	į	as indicated.		100
		cord that the identified		4. Executive Director/Director	or of Clinical	į.
	A	reviewed and what, if any,	- Si	Services will conduct pharms	acv medication	1
		n to address it. If there is to		review on 10 percent of the i	-	
		nedication, the attending ument his or her rationale in	1	monthly for 3 months, to ens		
	the resident's medica		i i	compliance. The Director of		1
	the resident's medica	record.	1	Services will report findings		Ŵ.
	8483 45(c)(5) The fac	cility must develop and	1	Committee monthly and Qua		1
		procedures for the monthly		Review schedule will be mod		T.
		that include, but are not	1	findings.	aniou baseu on	i
		s for the different steps in		iniunigs.		1
		s the pharmacist must take		3		1
		fies an irregularity that		1	*	:
	requires urgent action	to protect the resident.	1	1		1
	This REQUIREMENT	is not met as evidenced	N.	· ·		*
	by:					:
		iew, facility document				
	review, and clinical re				6.	
		acility staff failed to respond				2
		nthly medication review		I I		E .
		one of 39 residents in the				1
		lent #62 (R62). The facility				1
	staff failed to follow u	•	i			in the second se
	recommendation to o		i			į
	determine R62's kidn	ey lunction.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN			(X3) DATE SURVEY COMPLETED	
		495203	B. WING		774.000	C 06/29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			900 VII	ET ADDRESS, CITY, STATE, ZIP CODE RGINIA AVENUE (ANDRIA, VA. 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	DBE	(X5) COMPLETION DATE
F 756	Continued From pag	ge 55	F7	756			
	The findings include	t e	1	1			7
	quarterly assessment reference date) of 50 being severely impa	MDS (minimum data set), a nt with an ARD (assessment /18/22, R62 was coded as dred for making daily cored 6 out of 15 on the BIMS mental status).					
	reviews for R62 reve The review docume assessment of renal past six monthsPlaneveal kidney function	thly medication regimen ealed a review dated 5/27/22. nted: "[R62] has not had an I (kidney) function within the ease monitor [blood tests to on] on the next convenient labory six months thereafter."					
	reveal any laborator 5/27/22 medication Further review of R6 the pharmacist had	62's clinical record revealed completed the June 2022					
	On 6/28/22 at 5:40 p staff member) #1, th	review for R62 on 6/23/22. o.m., ASM (administrative lie executive director, and r of nursing, were informed of		The state of the s			
	was no way to defer performed. She state recommendations of either the director of director of nursing to items requiring an o	ome from the pharmacy, f nursing or the assistant poks through them and takes order to the physician. She former director of nursing had		The second secon			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495203	B. WING_		C 06/29/2022
	OVIDER OR SUPPLIER ALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP CO 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ION SHOULD BE COMPLETION DATE
F 756	stated she had spok in an order for the la performed on R62 e stated the contract is residents' laboratory. Tuesdays and Thurs times if urgent. A review of the facilit Regimen Review," in pharmacist will addr. MRRs (medication in Director of Nursing a and to the Medical E not require urgent are before the consultar MRR, the facility stapharmacist will confirmacist will will confirmacist	me from the pharmacist. She en with the physician and put boratory tests to be arlier in the morning. She aboratory company performs tests on regularly on idays, and at other requested by policy, "Medication		756	
F 804	Nutritive Value/Appe CFR(s): 483.60(d)(1 §483.60(d) Food an Each resident receiv §483.60(d)(1) Food conserve nutritive values §483.60(d)(2) Food attractive, and at a stemperature. This REQUIREMEN by:	d drink yes and the facility provides- prepared by methods that alue, flavor, and appearance; and drink that is palatable,	# # # # # # # # # # # # # # # # # # #	1. Meals served to Reside #37, and Resident #50 has acceptable temperature liftemperature are taken between the units. Food Service M dietary staff to ensure the warmer to maintain food to 2. All the residents that reare at risk to be impacted deficient practice. 3. Food Services Manage dietary staff on the use of order to maintain the food An audit will be done by Manager to ensure timely trays.	mit, meal fore sending out to lanager educated y are using plate emperature. loceive a meal tray by the alleged er will educate plate warmer in I temperature. the Food Services

	FDEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING_		COMPLETED	
			522		c	;
		495203	B. WING		06/2	9/2022
NAME OF PR	OVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ENVOYOF	ALEXANDRIA, LLC			00 VIRGINIA AVENUE		
			A	LEXANDRIA, VA 22302		10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	H			Continued From page 57	,	
F 804	Continued From page	9 57	F 804			
	Interview, facility document review and clinical			4. Food Services Manager/food services		
	record review, the fac	cility staff failed to serve food	¥	assistant will audit 5 trays each we		
	at a palatable temper	ature for 3 of 39 residents in	i	weeks then monthly for 2 months	to	
	the survey sample, R	esidents #50, #34 and #37.		ensure proper food temperature i	S	
				maintained. Findings will be repor	ted to	
i	The findings include:			the QAPI Committee monthly and	Quality	
	0 5 11 4 150 15			Monitoring Review schedule will be	•	
		R50) most recent MDS		modified based on findings.		
	,	a quarterly assessment with		anounce based on mangs.		
		t reference date) of 5/5/22, 5 out of 15 on the BIMS				
		ental status), indicating the		1		
		ively impaired for making				
	-	6/27/22 at 1:42 p.m., an				
		cted with R50 and the	Q.	1		
	resident stated the fa			1	1	
	On Resident #34's (F	(34) most recent MDS	į			
		a quarterly assessment with	•	! !		
		t reference date) of 4/21/22,				
		5 out of 15 on the BIMS	31			
		ental status), indicating the		İ		
		ively impaired for making				
		8/27/22 at 2:59 p.m., an				
		cted with R34 and the ood was usually cold when				
	served.	od was usdaliy cold when				
	On Booldent #97% /F	227) most recent MDC	i	I. V.		
		R37) most recent MDS a quarterly assessment with	- 3			
		t reference date) of 4/22/22,	i			
	•	5 out of 15 on the BIMS				
		ental status), indicating the	i			
	•	ively impaired for making				
		6/27/22 at 3:13 p.m., an				
		cted with R37 and the				
	resident stated the fa					
	On 6/28/22 at 1:02 n	.m., a meal test tray was		•		5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:			(X3) DATE SURVEY COMPLETED	
		495203	B. WING _			C 29/2022
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		25/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 812	was being served. T were taken by OSM (food services manag OSM #5 (the district of The pureed carrots w (Fahrenheit), the pure and the pureed fish was tasted by two su #5. OSM #4 stated to and OSM #5 agreed. On 6/28/22 at 5:40 p. staff member) #1 (the ASM #2 (the director aware of the above of the facility policy title Production/Preparation to the most current F methods that consentiation further information.	tresident on the last unit the temperatures of the food other staff member) #4 (the er) and read by OSM #4 and food services manager). were 98 degrees eed bread was 110 degrees was 100 degrees. The food rveyors, OSM #4 and OSM the food, "could be hotter" m., ASM (administrative e executive director) and of nursing) were made oncern. ed, "Food on" documented, "Food will anitary condition as outlined DA Food Code using we nutritive value, quality, the." In was presented prior to exit. Store/Prepare/Serve-Sanitary 2) ty requirements.	F8		second floor ration beyond e was discarded d on facility	8/3/2022
	approved or consider state or local authorit (i) This may include from local producers and local laws or reg	red satisfactory by federal, ies. food items obtained directly , subject to applicable State		by the alleged deficient pro A quality review was conding Dietary Manager and Unit the nourishment room ref ensure that there were no per the facility food policy	ucted by the Manager on all rigerators to expired items	

OLITICIT	O I OIT NIEDIOMILE OF	INCOIOTID OFIANOEO		OMD 140. 0000-000 1			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
		4		С			
		495203	B. WING	06/29/2022			
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
ENVOY O	FALEXANDRIA, LLC		900 VIRGINIA AVENUE				
	,		ALEXANDRIA, VA 22302				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION			
			Continued From page 5	59			
F 812	Continued From page	ə 59	F 812 3. Unit Managers/Dietary Ma	anager will 8/3/2022			
	facilities from using p	roduce grown in facility	educate all staff regarding fo	od storage,			
		ompliance with applicable	monitoring and discarding fo	od per			
	safe growing and foo		manufactural recommendati	·			
		es not preclude residents	policy.	orraina racincy			
	from consuming food	Is not procured by the facility.	4. Director of Clinical Service:	=/Assistant			
			17 82	•			
		prepare, distribute and	Director of Clinical Services w				
	9.0	ance with professional	Quality Monitoring Review o				
	standards for food se		room refrigerators for food storage and				
		「 is not met as evidenced	expiration dates to ensure no	o expired items			
	by:	m - t-ff into-doug and for this.	are present 5 days a week fo	r 4 weeks,			
		on, staff interview and facility a facility staff failed to store	then monthly, for 2 months,	to ensure			
		er in 1 of 3 unit nourishment	compliance. The Director of	Clinical			
		e second floor nourishment	Services/Assistant Director o				
	room.		Services will report findings t	to the QAPI			
	The second floor no	urishment room refrigerator	Committee monthly and Qua	42			
		od items that were past the	Monitoring Review schedule	will be			
	manufacturers' use b	•	modified based on findings.	1			
		•	A	Ē.			
	The findings include:						
	5			į.			
	-	m., observation of the	20				
		ment room refrigerator was					
		(licensed practical nurse) #4.		1			
		served: one 2 pound block					
		eese with a best by date of e can of whipped topping		1			
		f 12/25/21, one 6.5 ounce	10	1			
		ng with a use by date of	1				
	• • • • • • • • • • • • • • • • • • • •	e bottle of creamy French					
		f used by date of 10/5/21	3				
	and one ham and che		E CONTRACTOR CONTRACTO	2			
	lunchable with a use	by date of 9/4/21. At that	II.				
	time, an interview wa	s conducted with LPN #4.	5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 -	1			
		mperature of the refrigerator	**	1			
		necked by a nurse every day	2				
	and at that time, the	nurse should check the food	*	7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
		495203	B. WING			29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP COE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		1.512.022	
(X4) ID PREFIX TAG	(EACH DEFICI	YSTATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F812	if used by date. Litems should have them in the trash. On 6/28/22 at 2:49 conducted with Odietary manager). staff delivers snac nourishment room primarily remove to refrigerators but her refrigerators and ruse by or best if use by or best if use the first of the f	othing is past the use by or best PN #4 stated all of the above is been discarded and threw 9 p.m., an interview was SM (other staff member) #4 (the OSM #4 stated the dietary exists and juices to the unit its. OSM #4 stated the nurses food items from the unit it e does so if he is in the notices foods that are past the sed by date. 9 p.m., ASM (administrative (the executive director) and stor of nursing) were made	F 81	2			
	The facility policy Foods" document Control for Safety refrigerated, will b accordance with g Code." No further information Dispose Garbage CFR(s): 483.60(l)(4)- Disproperly. This REQUIREMIND: Based on observing document review,	titled, "Food Storage: Cold ed, "All Time/Temperature (TCS) foods, frozen and e appropriately stored in juidelines of the FDA Food ation was presented prior to exit. and Refuse Properly	F 8	1. Garbage Refuse Dumps properly to ensure a sanita environment to diminish an rodents, flies and or birds. 2. All residents are at risk impacted by the alleged de A quality review was condudumpsters to ensure clean Environmental/Housekeep the Dietary Director have be the Executive Director on to "Dispose of Garbage and F	for being eficient practice. ucted of all and secured. bing Director and been educated by the policy	8/3/2022	

	· · · · · · · · · · · · · · · · ·	MEDIONIO CENTIQUES				CITIO 140	7. 0000-000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE	
		495203	8. WING			l .	20/2022
NAME OF DE	ROVIDER OR SUPPLIER	470200	1		TREET ADDRESS, CITY, STATE, ZIP CODE	06/	29/2022
THE OF FE	CONDEN ON OUTFLIER				00 VIRGINIA AVENUE		
ENVOY OF	FALEXANDRIA, LLC		İ		LEXANDRIA, VA 22302		
		·	100		·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
E 04.4	0				Continued From page 61		
r 814	Continued From page		F	814			
	two of two dumpsters	s containing trash.	î		such all garbage and refuse will be collected and disposed of in a safe a	nd	8/3/2022
	On 6/00/00 the allidia	an aida daan af tu	1		Including properly closing the lid and		
	On 6/28/22, the slidir	ng side doors of two erved open and multiple flies	1		doors of the dumpsters after every u		
	were inside the dump				3. Executive Director will educate al		
	inolae tro damp				dietary and maintenance staff on		
	The findings include:				cleanliness and security of the dump		
	g=		;		The Environmental Director will mon		
		.m., an observation of the			dumpster area ensuring lids fully clo	sed and	
		as conducted. Two of two			secured and area is clean.		
		g trash were observed with			4. Executive Director will conduct qu		
		rs completely open. Multiple	78		monitoring audits weekly for 4 week	s tn o n	
		dumpsters. No staff was			monthly for 2 months to ensure the dumpster lids are closed and the are	a ie	
	utilizing the dumpster	rs at this time.			clean The DCS will report findings to		
	On 6/28/22 at 2:50 n	.m., an interview was	1		QAPI Committee monthly and Quali		
		l (other staff member) #4 (the			Monitoring Review schedule will be	-,	
		SM #4 stated the side doors			modified based on findings.		
		e supposed to be closed so					
	rodents, flies and bin	ds aren't attracted to the	1				
	area.						
	0-00000 +0.55						
		.m., an interview was					
		1#7 (the housekeeping stated the side doors on the					:
		stated the side doors on the closed if staff is not					10
		#7 stated rodents, flies and			1		
	"anything" can crawl						
	On 6/28/22 at 5:40 p.	.m., ASM (administrative					
	staff member) #1 (the	e executive director) and					1
		of nursing) were made					
	aware of the above o	concern.	ŀ				1
	The 6-116-11-11-11-11-11-11-11-11-11-11-11-1	1 110					
		ed, "Dispose of Garbage and					1
		d, "All garbage and refuse will posed of in a safe and					į
	efficient manner."	poseu oi iii a sait allu					
	Janorom manner.						
					i .		

CENTER	S FOR MEDICARE & 1	MEDICAID SERVICES			OMB NO	O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION G	COME	(X3) DATE SURVEY COMPLETED	
		495203	B. WING_			C /29/2022	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		ZUZZZ	
				900 VIRGINIA AVENUE			
ENVOYOR	FALEXANDRIA, LLC			ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 814	Continued From page	\ 62	F.0.				
1,014	, -		F8	14			
E 040	Use of Outside Resor	was presented prior to exit,	in the	40			
	CFR(s): 483.70(g)(1)		F 84	40 1. Resident #85 no longer res		8/3/2022	
00-D	OF 14(a), 405.70(g)(1)	141		center. On 06/30/2022 dialys			
0	§483.70(g) Use of ou	Iside resources.	15	was signed by Fresenius Med	lical Care of	4	
	- 101	acility does not employ a	1	North America.		4	
		person to furnish a specific	ŧ	2. All residents on dialysis are	e at risk to be	1	
		d by the facility, the facility		impacted by the alleged defi-	cient practice.		
8		e furnished to residents by a	8	A quality review was conduct	ted by the	1	
		side the facility under an	-	Executive Director to ensure		S	
		ed in section 1861(w) of the	E.	facilities being used by our re			
		described in paragraph (g)		an active contract with the fa		1	
	(2) of this section.		8.	3. Executive Director/Director	•		
	8483.70(a)(2) Arrana	ements as described in		Services will educate admissi		1	
	section 1861(w) of th					1	
	pertaining to services			ensuring that the facility has		1	
	resources must spec	ify in writing that the facility	10	contract for any dialysis patie	ent before	1	
	assumes responsibili			accepting them.			
25		that meet professional	!	The Unit Managers will notif	•	2	
	standards and princip		1	Director when any resident is		1	
	protessionals providir and	ng services in such a facility;		initiating dialysis so the facili	ty can ensure		
	ਂ (ii) The timeliness of	the convince	6:	that an active contract is in p	olace.		
11 8		is not met as evidenced	17	4. Executive Director will cor	iduct an audit	8	
	by:	io not mot do ovidonosa		on all admitted/newly order	ed dialysis		
	=	iew, facility document review		residents monthly for 3 mon	th to ensure		
		view, the facility staff failed	1	compliance. Findings will be			
	to evidence a current	dialysis contract between	1	the QAPI Committee monthl	-		
	-	tpatient dialysis center		Monitoring Review schedule			
		one of 39 residents in the		modified based on findings.	TELL MA		
	survey sample, Resid	dent #85.		inounieu paseu on maings.			
	The findings include:		Í				
		(85) most recent MDS	į				
		an admission assessment	1			1.5	
	with an ARD (assess	ment reference date) of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		495203	B. WING		<u></u>	06/	/29/2022	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
ENVOY OF	FALEXANDRIA, LLC			900 \	VIRGINIA AVENUE			
				ALE	XANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION OATE	
F 840	Continued From p	age 63	F	840			1	
	6/9/22, the resided BIMS (brief Intervithe resident is not daily decisions.	nt scored 13 out of 15 on the lew for mental status), indicating cognitively impaired for making			٥			
	documented R85 R85's clinical reco dated 6/21/22 for Wednesday and F	fication form dated 5/20/22 required dialysis. A review of ord revealed a physician's order dialysis every Monday, fiday. A review of the facility failed to reveal a contract for vider.	manifement of the particular of the control of the					
	staff member) #2 provided a letter a executive director documented, "(R8 receiving dialysis since June 5, 202 patients from (nar treatments, a requ Facility Outpatien dialysis center) pa	12 p.m., ASM (administrative (the director of nursing) addressed to ASM #1 (the) and dated 6/28/22. The letter (\$5) (a mutual client) has been with (name of dialysis center) 2. In anticipation of other ne of facility) requiring dialysis uest for a Long-Term Care t Agreement to the (name of a learn has been ne of dialysis center)	The second secon					
	conducted with Ascentract R85's dia until this date. As dialysis facility on above letter. ASM	8 p.m. an interview was SM #1. ASM #1 stated a slysis center was not established SM #1 stated he went to the this date and received the M #1 stated an agreement d on the next date.					1	
		0 p.m., ASM #1 and ASM #2 of the above concern.						
	On 6/29/22 at app	proximately 11:47 a.m., ASM #1					İ	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495203	B. WING _		C 06/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 842	been developed. The facility policy title Hemodialysis Service requiring an outside Edisease) facility will he the facility. There will the facility and the ES resident. The facility Agreement/Arrangement/Arrangement residents requiring Diagreement shall incluto be managed."	d, "Coordination of ss" documented, "Residents SRD (end stage renal ave services coordinated by be communication between SRD facility regarding the will establish a Dialysis nent if there are any alysis Services. The de how the residents care is a was presented prior to exit. Ientifiable Information		1. Nursing staff on the unit proper 1:1 supervision docupaperwork by writing OOF(umentation
	(i) A facility may not resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical research (iii) In accordance identifiable to accordance with a coagrees not to use or except to the extent to do so.	elease information that is of an agent only in intract under which the agent elisclose the information in facility itself is permitted ecords. In additional ecords and practices, the facility all records on each resident ented; e; and		instead of initialing their na documentation presented for days he was out of the fachest pain. 2. All residents in the facility be impacted by the alleged practice. A quality review was conducted any resident on 1:1 supaccurate documentation in record. 3. Director of Clinical Service Managers will re-educate degrading proper and accurate documentation for 1:1 supaccuration for 1:1 supaccuration to ensure accurate accur	for resident #37 for resident #37 facility due to y are at risk to deficient acted to ensure pervision had their medical ces/Unit direct care staffs rate ervision aracy in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3.33	CONSTRUCTION	(X3) DATE :	
		495203	B. WING		C 06/29/2022	
	ROVIDER OR SUPPLIER		90	TREET ADDRESS, CITY, STATE, ZIP CODE 10 VIRGINIA AVENUE LEXANDRIA, VA 22302	-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	all information contain regardless of the form records, except when (i) To the individual, or epresentative where (ii) Required by Law; (iii) For treatment, par operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic vactivities, judicial and law enforcement purpourposes, research p	ility must keep confidential ned in the resident's records, in or storage method of the release is- or their resident permitted by applicable law; yment, or health care ted by and in compliance		Continued From page 65 Unit Managers will notify the interdisciplinary team when a siturarises that requires a resident to be on 1:1 supervision so that the appostaff can be notified and document requirements discussed and review 4. Director of Clinical Services/Ass Director of Clinical Services will co Quality Monitoring Review of residuho are placed 1:1 observation data week for 4 weeks, then monthly months. The Director of Clinical Sewill report findings to the QAPI Co	e placed ropriate tation ved. stant nduct lents for 3 x for 2 rvices mmittee	
	a serious threat to he by and in compliance §483.70(i)(3) The fac	alth or safety as permitted with 45 CFR 164.512. illity must safeguard medical ainst loss, destruction, or	1	monthly and Quality Monitoring R schedule will be modified based o findings.		
	for- (i) The period of time (ii) Five years from the there is no requirement	ars after a resident reaches				
	(ii) Sufficient informati (iii) A record of the res (iii) The comprehens provided;	dical record must contain- ion to identify the resident; sident's assessments; ive plan of care and services y preadmission screening				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		495203	B. WING _		06/29/2022
	FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP CO 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	DOE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HEAPPROPRIATE DATE
	services reports as re This REQUIREMENT by: Based on resident int facility document revie It was determined tha maintain a complete a for one of 39 resident Resident #37. The findings include: Resident #37's (R37) (minimum data set), a an ARD (assessment the resident scored 1: (brief interview for me indicating the residen making daily decision On 6/27/2022 at 1:56 conducted with R37 in observed to have a st of the room in a chair stated that the previou with another resident and now a staff memi- and went with them w	evaluations and proted by the State; bys, and other licensed as notes; and logy and other diagnostic aquired under §483.50. This not met as evidenced aterview, staff interview, ew and clinical record review at the facility staff failed to and accurate medical record is in the survey sample, most recent MDS a quarterly assessment with a reference date) of 4/2/2022, 5 out of 15 on the BIMS ental status) assessment, at is cognitively intact for its. p.m., an interview was in their room. R37 was taff member sitting outside it monitoring the room. R37 us Friday they had a fight who lived across the hall ber sat outside their door whenever they went outside of that they had been in the	F8	42	
	in part:	or Resident #37 documented			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	P 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495203	B, WING				C /29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC		·	900 VI	ET ADDRESS, CITY, STATE, ZIP CODE IRGINIA AVENUE KANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	40.0	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X6) COMPLETION DATE	
F 842	with pain score of 9/1 he has been having in about a week, stated thought it will go awar Percocet 5/325mg 1 is Supervisor notified. [I at 9:45, order to trans (emergency room) fo Resident transferred at 10:30 am. all schemedications administicalled in to [Name of placed to ER to checispoke to [Name of state been admitted for Ch-"5/3/2022 18:13 (6:"currently in room alor supervision to ensure Resident's guardian acurrent status." On 6/28/2022 at 1:10 to ASM (administrative director of nursing, for R37 from 5/2/2022 conducted with OSM admission coordinated outside of R37's room that they were assign day. OSM #6 stated been on 1 to 1 since	on 5/23/2022" 1:07 a.m.) Note Text: al." :09 p.m.) Note Text: of chest Pain on left side 0 at around 9:35am. Stated ntermittent chest pain for I that he did not tell any staff y but pain is worse tab (tablet) given at 9:40 am. Name of Physician] notified offer Resident to ER or further evaluation. to ER at [Name of Hospital] duled am (morning) ered prior to transfer. Report staff] at 10:35am. Call k on Status of Resident, aff] was told Resident has est pain."	F	842				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			T. Boile Dill		С
		495203	B. WING _		06/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP CO 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE	ON SHOULD BE COMPLETION HEAPPROPRIATE DATE
F 842	who the other resider another room. OSM	ated that they did not know nt was but knew they were in #6 stated that they were	F 8	142	
	abusive behaviors. (able to leave the room wherever they went a go to smoke with the stated that they com	y aggressive behaviors or DSM #6 stated that R37 was m but they escorted them and they were not allowed to other residents. OSM #6 pleted documentation of the paper forms kept in a binder			
	conducted with OSM the director of social that R37 had been or resident to resident a OSM #10 stated that	15 a.m., an interview was (other staff member) #10, services . OSM #10 stated in 1 to 1 monitoring since the altercation on 6/24/2022. It they knew R37 was on 1 to that incident but was not			
	conducted with LPN LPN #7 stated that R and had a chaperone the altercation on 6/2	64 p.m., an interview was (licensed practical nurse) #7. 637 was on 1 to 1 monitoring 6 if they left the room since 64/2022. LPN #7 stated that 65 was off and on based on			
	behaviors for resider when to stop by the	nts and they were informed director of nursing. LPN #7 Imented the 1 to 1 monitoring	C TO COMPANY CONTRACTOR OF THE		
	conducted with ASM member) #2, the dire stated that R37 was court to have the gua stated that R37 had	p.m., an interview was (administrative staff actor of nursing. ASM #2 competent and had been to ardianship lifted. ASM #2 previously damaged a facility se would not give them			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C
		495203	8. WING		06/29/2022
NAME OF PROVIDER OR SUPPLIER ENVOY OF ALEXANDRIA, LLC				STREET ADDRESS, CITY, STATE, ZIP O 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE COMPLETION DATE
F 842	additional pain med the police had come to the police saying anything. ASM #2 scapacity and the pocould not do anything previous DON (dire R37 to a private roomonitoring at that ti further behaviors. A ended the 1 to 1 mode because R37 was mand the physician hifted. ASM #2 stated physician fax over a #2 stated that they documentation regard Con 6/28/2022 at ap #2 provided 1 to 1 mittled "Resident Saf prescription dated 5 documented, "D/C of the policy in the p	ge 69 ications. ASM #2 stated that a at that time and R37 had lied they did not remember stated that R37 did not lack lice knew they were lying but ng. ASM #2 stated that the ector of nursing) had moved om and placed them on 1 to 1 me and there had been no ASM #2 stated that they had onitoring around 5/24/2022 not displaying any behaviors ad determined that it could be ed that they were having the a note documenting this. ASM were gathering the requested arding the 1 to 1 monitoring. proximately 4:15 p.m., ASM monitoring documentation ety Check" and a copy of a 5/24/22 for R37 which (discontinue) sitter, patient has No signs of him being risk to	F	842	
	documents provide completed 5/2/2022 6/24/2022-6/27/202 safety checks docu completed on 5/21/5/22/2022 at 4:00 pp.m11:45 p.m. Th R37 being admitted after leaving at 10:3 facility on 5/23/2022 evidence a readmiss	ident Safety Check" d evidenced 15 minute checks 2-5/24/2022 and 22. Further review of the mented 15 minute checks 2022 from 10:30 a.m. through a.m. and 5/22/2022 7:00 be clinical record documented I to the hospital on 5/21/2022 30 a.m. and readmitting to the 2. The clinical record failed to esion time on 5/23/2022, lent Safety Check" document			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED	
		495203	B. WING		C 06/29/2022
NAME OF PROVIDE	R OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	00/23/2022
ENVOY OF ALE	(ANDRIA, LLC		1	VIRGINIA AVENUE EXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
	inued From pag	e 70 safety checks starting at	F 842		
	0 a.m. on 5/23/2	•			
		08 a.m., an interview was			
		I #5, medical doctor. ASM #5 of for R37. ASM #5 stated	i l		
		4/2022 and discontinued the	1 3		
1 to 1 sitter. ASM #5 stated that they did not write a note in the medical record because it was a quick visit and they just "eyeballed" R37. ASM #5		1			
		- 1			
		1			
		nal practice was to document			
		significant change or needed	- 9		la de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de
10.4		led that the DON had asked			1
		and written the prescription and had taken it back to their			1
100		e to be placed in a file. ASM	8	2	*
		vere sure that it had been			100
		prior to 6/28/2022 to be in the			50
		the DON had asked them to			
		tated that they based the	10		
		1 to 1 monitoring on their			i i
	_	ime and currently R37			
		oring until they could be			
	ly discharged.	•			
On f	3/29/2022 at 11 [.]	19 a.m., an interview was	T .		
		#2, director of nursing. ASM	#		
		1 to 1 monitoring was	i i		F3
		1/2022 when they asked the			
		ecause the nurses notes			
	•	ere compliant and had no			
		stated that the note from the			
· phys	sician dated 5/24	1/2022 should be a part of the	1		1
		M #2 stated that their medical	1		
	•	had been out and things			
		#2 stated that they had looked			1
		cal records and were not able			i i
		ney had asked the physician			
≘ to se	and it over. ASM	#42 was asked about the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY COMPLETED	
	495203	B. WING		C 06/29/2022
NAME OF PROVIDER OR SUPPLIER ENVOY OF ALEXANDRIA, LLC		900	EET ADDRESS, CITY, STATE, ZIP CODE VIRGINIA AVENUE EXANDRÍA, VA 22302	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
provided which documinutes on 5/21/2022 to the emergency roc 5/22/2022 with the exp.m. when they were ASM #2 stated that the safety checks for On 6/29/2022 at 12:3 they had reviewed th 5/21/2022 and 5/22/2 they had spoken with they meant and it appeducation on how to #2 stated that staff with the meant and the organ on the form. ASM #2 have the residents not accurate and the organ documentation needs. The facility policy "Clar revision date of 8/2"Clinical records are with professional pracomplete and accurate sident for continuity clinical record is to desident's plan of care of communication and professionals involved On 6/29/2022 at 12:50 executive director, Anursing and ASM #4	mented checks every 15 2 after R37 had transferred om, and every 15 minutes on acception of 4:15 p.m6:45 admitted to the hospital. hey would have to validate those days. 14 p.m., ASM #2 stated that a safety checks for R37 for 2022. ASM #2 stated that a the staff to find out what beared to be a lack of document on the form. ASM are initialing the form rather at of facility) on the form and gothe residents information 2 stated that the form should ame and the record was not anization of the ed to be corrected. inical/Medical Records" with 5/2017 documented in part, we maintained in accordance ctice standards to provide ate information on each by of care. The purpose of the ocument the course of the course and to provide a medium anong health care and in this care"	F 842		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FUR MEDICARE & I	MEDICAID SERVICES			OWR	NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495203	B. WING		0	C 6/29/2022	
NAME OF PR	ROVIDER OR SUPPLIER	,	- 	STREET ADDRESS, CITY, STATE, ZIP COD		-, -, -, -, -, -, -, -, -, -, -, -, -, -	
				900 VIRGINIA AVENUE			
ENVOY OF	FALEXANDRIA, LLC			ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 842	Continued From page	72	F 8	42		İ	
		was provided prior to exit.					
F 883		ococcal Immunizations	: FA	83 1. Resident #56's responsib	le narty was	9/2/2022	
	CFR(s): 483.80(d)(1)		. 10			8/3/2022	
		;- <i>i</i>	:	called to get consent and ed			
9	§483.80(d) Influenza	and pneumococcal	1.2	benefit of pneumococcal va		į.	
:	immunizations			to R#56 age, verbal consent	_	1	
		za. The facility must develop		administration of the vaccin		3	
	policies and procedur			order and administered to	Resident #56.		
		influenza immunization,		2. All residents at risk for be	eing impacted		
		resident's representative		by the alleged violation.		1	
	receives education re potential side effects	egarding the benefits and		A quality review of resident	s'	1	
	(ii) Each resident is o			pneumococcal vaccine stat		4	
	immunization Octobe			completed and pneumococ		s	
		mmunization is medically		offered if indicated.	Towarity TVC	_	
		resident has already been	1	3. Director of Clinical Service	es/Hnit		
	immunized during this	s time period;					
		e resident's representative	ii.	Managers will educate nurs	-		
		refuse immunization; and	100	policy of pneumococcal vac	-	IU ;	
	(iv)The resident's me		100	be educated to obtain info	•		
		idicates, at a minimum, the		admission and ensuring the			
	following:	or real deaths representative		forms are obtained and pla	ced into the		
		or resident's representative on regarding the benefits	ř.	medical record.			
1	and potential side effe			4. Director of Clinical Service	es/Unit	8	
1	immunization; and	JOS OF HIMOHER	i	Managers to complete a Q	uality	1	
		elther received the influenza	ļ	monitoring audit on all nev	•	215	
		ot receive the influenza		pneumococcal status week		1	
	immunization due to	medical contraindications or		then monthly for 2 months	•	•	
	refusal.			compliance. The Director o			
				Services will report finding			
		nococcal disease. The facility		· -		A	
		and procedures to ensure	į	Committee monthly and Q	•		
	that-	nnoumonos-si	5	Monitoring Review schedu		i	
	(i) Before offering the		1	modified based on findings	i.	i	
		esident or the resident's res education regarding the	100			1	
	benefits and potentia		90,	-		T	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495203	B. WING _			C 06/29/2022	
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 883	immunization; (ii) Each resident is o immunization, unless medically contraindic already been immunization. The resident or the has the opportunity to (iv) The resident's medocumentation that in following: (A) That the resident was provided education and potential side effirimmunization; and (B) That the resident pneumococcal immunization; and (B) That the resident pneumococcal immunization or retries REQUIREMENT by: Based on staff interview, it was determ failed to offer, obtain education regarding to one of five resider record review, Resider the findings include: The facility staff failed provide education requarted to the resident was coding term memory directly determined the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed the resident was coding term memory directly staff failed to the resident was coding term memory directly staff failed to the resident was coding term memory directly staff failed to the resident was coding term memory directly staff failed to the resident was coding term memory directly staff failed to the resid	ffered a pneumococcal the immunization is sated or the resident has zed; se resident's representative or refuse immunization; and dical record includes adicates, at a minimum, the or resident's representative on regarding the benefits ects of pneumococcal either received the nization or did not receive amunization due to medical fusal. It is not met as evidenced riew and clinical record sined that the facility staff consent and/or provide the pneumococcal vaccines ants in the immunization ents # 56 (R56).	F	383			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495203	B. WING				C 06/29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			900 VIR	ADDRESS, CITY, STATE, ZIP CODE GINIA AVENUE ANDRIA, VA 22302		30/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICI	RY STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 883	daily decisions. Under the preumococcal value of the Gelectronic health the pneumococcal value of the pneumococcal value o	Under Section "O Special edures and Programs" (R56) being offered the	F	883				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495203	B. WING_			C 29/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		53	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION SHOOT CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPOPULATION OF THE APPOPULATION OF THE APPOPULATION OF THE APPOPULATION OF THE APPOPULATION OF THE APPOPULATION OF THE APPOPULATION OF T	OULD BE	(X5) COMPLETION DATE	
F 883	documented in part, " admission, residents a eligibility to receive the series, and when indivaccine series within to the facility unless in the resident had alreade Before receiving a progression of legal representation and educated potential side effect vaccine." On 06/29/2022 at approximation and potential side effect vaccine." On 06/29/2022 at approximation (administrative staff in director, ASM # 2, director, ASM # 2, director, ASM # 2, director, ASM # 2, director, ASM # 3, director of made aware of the final No further information (CFR(s): 483.90(d)(3) §483.90(d)(3) Conducted frames, mattress part of a regular main areas of possible entrand mattresses are useparately from the bensure that the bed reframe are compatible. This REQUIREMENT by: Based on staff interview, it was determined the service of the service	Ineumococcal Vaccine" 1. Prior to or upon will be assessed for e pneumococcal vaccine cated, will be offered the thirty (30) days of admission nedically contraindicated or ady been vaccinated3. eumococcal vaccine, the esentative shall receive atlon regarding the benefits ects of the pneumococcal vaccine where the preumococcal vaccine, the esentative shall receive atlon regarding the benefits ects of the pneumococcal vaccine, the extensive shall receive atlon regarding the benefits ects of the pneumococcal vaccine, the ector of nursing and ASM # dinical services, were edings. In was presented prior to exit. In the Regular inspection of all es, and bed rails, if any, as tenance program to identify apment. When bed rails sed and purchased ed frame, the facility must ealls, mattress, and bed		1. All four residents identified in (Resident#16, Resident #66, Rand Resident #45) have had the safety check completed for risk entrapment, including bed matte compatibility, bed rails usage a usage for safety, security and withe residents 2. All residents are at risk for beimpacted by the alleged deficient A quality review of all beds was to ensure proper functioning. It have their bed safety check conquarterly basis and upon admission accordingly. This will include in mattresses, bed compatibility, bed rails usage for safety and safety an	desident #96 deir bed do of tress/frame and side rails well-being for eing ent practice. Is completed They will mpleted on a ssion, nspection of side rails and security, free		

NAME OF PROVIDER OR SUPPLIER ENVOY OF ALEXANDRIA, LLC (XVI)D			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER ENVOY OF ALEXANDRIA, LLC SUMMARY STATEMENT OF DEPICIENCES BOO VIRGINIA AVENUE ALEXANDRIA, VA 22382 ALEXANDRIA, VA 22382 F 900 Continued From page 76 F 900 Continued From page 76 F 900 Continued From page 76 In the facility staff failed to inspect Resident #16's Resident #96 and Resident #16's bed for risk of entrapment. Resident #16's most recent MDS (minimum data set) assessment, a quarterly assessment, a quarterly assessment reference date of 3/20/22, coded the resident associng 15 out of 15 on the BIMS (brief interview for mental status), soon, adicating the resident was cognitively intact. MDS Section GFunctional Status, coded the resident associang 15 out of 15 on the BIMS (brief interview for mental status), soon, adicating the resident was cognitively intact. MDS Section GFunctional Status, coded the resident as roquiring extensive assistance in bed mobility and transfers. On 6/27/22 at 1:45 PM, 6/28/22 at 10:00 AM and 6/29/22 at 1:30 AM, 1/4 side rails were observed to be in use. On 6/27/22 at 1:45 PM, 6/28/22 at 10:00 AM and 6/29/22 at 5:00 PM, a request was made for evidence of the documentation of the annual bed safety inspection for the entire facility. There was no evidence of the documentation of resident he following, "Side Rails: 1/4 side rails for bed inspection for challenge and propriet and propr				A. BUILUI				С
PANE OF PROVIDER OR SUPPLIER ENVOY OF ALEXANDRIA, LLC (p(x)) to PREFIX TAGE REGULATORY OR LSC IDENTIFYING INFORMATION) F 909 Continued From page 76 4 of 39 resident 8 in the survey sample, Resident #16; Resident #66, Resident #96 and Resident #16's bed for risk of entrapment. Resident #16 was admitted to the facility on 6/15/16 with diagnoses that included but were not limited to: psychotic disorder and anxiety disorder. Resident #16's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 32/20/2, coded the resident was cognitively intact. MDS Section G-Functional Status, coded the resident as requiring extensive assistance in bed mobility and transfers. Observation of Resident #16 resting in bed on 6/27/22 at 1:45 PM, 9/28/22 at 1:000 AM and 6/29/22 at 5:00 PM, a request was made for evidence of the documentation of the annual bed safely inspection for the entire facility. There was no evidence of the documentation for Resident, 146 realis vere observed to be in use. The physician's order dated 7/28/20, revealed the following, "Side Rails: 1/4 side rails for bed for the other contents of the documentation for Resident, #16. The physician's order dated 7/28/20, revealed the following, "Side Rails: 1/4 side rails for bed for the other contents of the documentation for Resident," and the following, "Side Rails: 1/4 side rails for bed for the contents of the documentation for Resident," and the following, "Side Rails: 1/4 side rails for bed for the contents of the documentation of the annual bed safely inspection for the entire facility. There was no evidence of the documentation for Resident," and the facility of the contents of the documentation for Resident, "Fig. 20, revealed the following, "Side Rails: 1/4 side rails for bed for the documentation for Resident," and the facility of the documentation for Resident, "Fig. 20, revealed the following, "Side Rails: 1/4 side rails for bed for the contents of the documentation of the contents of the docu			495203	B. WING			06	/29/2022
SUMMANY STATEMENT OF PREFICENCES BY TULL (PROD DESCRICTORY OF USE OF PROTECTION (PROD STATE OF THE PROPORTION OF USE OF PROPERTY OF USE APPROPRIATE CONSTRUCTION OF USE OF PROPERTY OF USE APPROPRIATE CONSTRUCTION OF USE A					900 VIR	RGINIA AVENUE		
F 909 Continued From page 76 4 of 39 residents in the survey sample, Resident #16, Resident #96 and Resident #45. 1. The facility staff failed to inspect Resident #16's bed for risk of entrapment. Resident #16 was admitted to the facility on 6/15/16 with diagnoses that included but were not limited to: psychotic disorder and anxiety disorder. Resident #16's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/20/22, coded the resident as scorning 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G-Functional Status, coded the resident as requiring extensive assistance in bed mobility and transfers. Observation of Resident #16 resting in bed on 6/27/22 at 1:45 PM, 6/28/22 at 10:00 AM and 6/29/22 at 6:30 AM. 1/4 side rails were observed to be in use. On 6/27/22 at 5:00 PM, a request was made for evidence of the documentation of the annual bed safety inspection for the entire facility. There was no evidence of the requested documentation for Resident #16. The physician's order dated 7/28/20, revealed the following, "Side Rails: 1/4 side rails for bed"	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
A review of the side rall evaluation dated 10/23/21, revealed the following, "Bed mobility:	F 909	4 of 39 residents in #16, Resident #66, #45. 1. The facility staff f #16's bed for risk of Resident #16 was a 6/15/16 with diagnolimited to: psychotic disorder. Resident #16's mos set) assessment, a assessment referencesident as scoring (brief interview for rithe resident was confounded by the resident was confounded by the resident was confounded by the resident was confounded by the resident was confolived by the resident was	the survey sample, Resident Resident #96 and Resident failed to inspect Resident failed to inspect Resident familiary and the facility on sees that included but were not codisorder and anxiety Strecent MDS (minimum data quarterly assessment, with an noce date of 3/20/22, coded the 15 out of 15 on the BIMS mental status) score, indicating agnitively intact. MDS Section as, coded the resident as assistance in bed mobility and sident #16 resting in bed on and, 6/28/22 at 10:00 AM and and the rails were observed PM, a request was made for commentation of the annual bed or the entire facility. There was requested documentation for ler dated 7/28/20, revealed the ils: 1/4 side rails for bed aning."	F	909 3. E Maii adm any imm up. Exe Sen supo of n insp add mai bed 4. E mor wee mor equ Sen corr Rev	Continued From page 76 xecutive Director will educantenance Director to audit the bission, quarterly and as indissues. Any issues will be nediately and reported to Effective Director and Director vices will notify the maintenervisor/assistant in daily clinew or pending admits for be pections to be completed. The determinance team and used for inspection tracking, executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking. Executive Director to complete inspection tracking.	peds on dicated with addressed of for follow or of Clinical meetinged of these will be the kept by the property for 2 doning and of Clinical the QAPI of Monitoring	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DPLAN OF CORRECTION UMBER: A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495203	B, WING _				C 29/2022
	OVIDER OR SUPPLIER		100	900 V	ET ADDRESS, CITY, STATE, ZIP CODE IRGINIA AVENUE KANDRIA, VA 22302		LUILUAL
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLÉTION OATE
F 909	side to side/holding the bed rall (s) assistand down in bed? In the resident in pulling position? Yes. Recorded the resident in pulling position? Yes. Recorded the side of th	assist the resident in turning self to one side? Yes. Will st the resident in moving up yes. Will the bed rail (s) assisting self from lying to sitting commendations: Side rails of the following, "FOCUS: has an daily living)elf-care related to General debility, nited Mobility, Contractures of NTERVENTIONS: Quarter obility & positioning." Inducted on 6/27/22 at 1:45 of 6. When asked if the ide rails, Resident #16 stated, help move in bed." Inducted on 6/28/22 at 2:40 or staff member) #2, the ician. When asked for the ician. When asked for the ician. When asked for the ician when asked in TELS rary system) for all beds. It is nothing in TELS rary system) for all beds. It is nothing was in the it worry about tracking was in the it worry about tracking was in the it worry about tracking was and bed numbers, could a for that bed be ran, OSM #2 was report for specific beds.	F	009			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495203	B. WING		С
NAME OF P	ROVIDER OR SUPPLIER	493203	B. WING_	STREET ADDRESS, CITY, STATE, ZIP COD	06/29/2022
ENVOY OF ALEXANDRIA, LLC				900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 909	per the manufacturer sure, this is my first the #2 stated, this is all the were provided a "TEL form which revealed Mattresses: Inspect E Check: Inspect connum as necessary. Remost to prevent injury. Vellatch-knob assembly, latch is free of dirt and could impair its function engage and lock as a replace any parts sure screws, etc., that are or are missing." The facility policy, "Si reviewed. This policy Center, will attempt a document in the med	M #2 was checking bed rails s, OSM #2 stated, I am not me seeing this policy. OSM he information I have as we as Logbook Documentation the following: "Beds & Bed Rails: Maintenance ectors on rails and tighten we any burs or rough edges fify the function on the spring if applicable. Ensure the d/or foreign material that on. Ensure that the rails pecified. Tighten, adjust or the as end caps, knobs, bolts, loose, show signs of wear ide Rail/Bed Rail" was a documented, "Policy: The lternative interventions, and ical record, prior to the use side rail/bed rail may include	F	909	
	but not limited to: Sic rails, grab bars and a prior to installation of the side rail/bed rail or resident for risk of en and benefits with the representative. 3. Of resident and/or resident	de rails, bed rails, safety ssist bars. Procedure: 1. a side rail/bed rail complete evaluation to evaluate the trapment. 2. Review the risk resident and/or resident otain consent from the ent representative. 4. er for side rail/bed rail. 5.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)		IDENTIFICATION NUMBER:		AULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495203	B, WING			06	C /29/2022
	ROVIDER OR SUPPLIER			900	REET ADDRESS, CITY, STATE, ZIP CODE VIRGINIA AVENUE EXANDRIA, VA 22302	00	12312022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 909	beds. The facility did manufacturer's recoms pecifications for the not logging and tracking and side rall inspection. On 6/29/22 at 12:40 F staff member) #1, the the director of nursing Director of Clinical Sethe above concerns. No further information. 2. The facility staff fail #66's bed for risk of expected with diagnose limited to: multiple scillimited to: multipl	pections of side rails and not have a manual of the amendations and side rails. The facility was ing routine or periodic bed ons. PM, ASM (administrative executive director, ASM #2, and ASM #3, the Regional divices were made aware of a was provided prior to exit. Ited to inspect Resident intrapment. In whited to the facility on east hat included but were not derosis. In the date of 3/20/22, coded the approximately assessment, with an eadate of 3/20/22, coded the approximately intact. MDS Section coded the resident assessistance in bed mobility;	F	009			
		mentation of the annual bed		-			

r ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:			(X3) DATE SURVEY COMPLETED
		495203	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE COMPLETION DATE
F 909	Continued From pag	ge 80	F:	909	
		r the entire facility. There was equested documentation for	5 = 0		
		er dated 7/28/20, revealed the ls: 1/4 side rails for bed ning."			53 53
	10/23/21, revealed a will the bed rail (s) a side to side/holding the bed rail (s) assistand down in bed? Ye the resident in pullir	rail evaluation dated the following, "Bed mobility: assist the resident in turning self to one side? Yes. Will st the resident in moving up Yes. Will the bed rail (s) assist ag self from lying to sitting tommendations: Side rails			
	dally living) self-care to MS (multiple scle prefers 18 revealed an ADL (activities of despite having cloth	Bilateral quarter bed rails for			
	PM with Resident # resident used the si	onducted on 6/27/22 at 1:35 66. When asked if the de rails, Resident #66 stated, to help myself turn and get			
	PM with OSM (other maintenance technic evidence of the anni OSM #2 stated, No	onducted on 6/28/22 at 2:40 or staff member) #2, the ician. When asked for the cual bed safety inspection, there is nothing in TELS rary system) for all beds.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495203	B. WING_	B. WING		C 06/29/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		0018012022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 909	OSM #2 stated, we week, but we do not previous director tole computer and to not anything on paper. given specific room report of inspection stated, no, there is rewhen asked for the recommendation for #2 stated, no I do not When asked how Oper the manufacture sure, this is my first #2 stated, this is all twere provided a "TE form which revealed Mattresses: Inspect Check: Inspect con as necessary. Rem to prevent injury. Velatch-knob assembly latch is free of dirt are could impair its funciengage and lock as replace any parts suscrews, etc., that are or are missing." The facility policy, "Sireviewed. This polic Center, will attempt document in the me	as checked on the beds, ook at the side rails every track the bed rails. The if me everything was in the worry about tracking was in the worry about tracking was in the worry about tracking was and bed numbers, could a for that bed be ran, OSM #2 or report for specific beds. In a side rails, OSM and thave that information. If was checking bed rails ray os was checking bed rails ray os was checking bed rails ray. OSM #2 stated, I am not time seeing this policy. OSM the information I have as we LS Logbook Documentation the following: "Beds & Bed Rails: Maintenance mectors on rails and tighten ove any burs or rough edges erify the function on the spring of, if applicable. Ensure the ad/or foreign material that tion. Ensure that the rails specified. Tighten, adjust or ch as end caps, knobs, boits, a loose, show signs of wear. Side Rail/Bed Rail" was by documented, "Policy: The alternative interventions, and dical record, prior to the use	FS	909			
	but not limited to: S rails, grab bars and prior to installation o	Side rail/bed rail may include ide rails, bed rails, safety assist bars. Procedure: 1. f a side rail/bed rail complete evaluation to evaluate the				A Company of the Comp	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	CY2) MULT	IDI E CONS	ETRUCTION	OMB NO. 0938-0391	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495203	B. WING			C 06/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET	TADDRESS, CITY, STATE, ZIP CODE		
ENVOY O	F ALEXANDRIA, LLC				RGINIA AVENUE ANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	'ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	κ _{//}	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 909	Continued From page	e 82	F	909		1	
		trapment. 2. Review the risk	1			4	
		resident and/or resident	1121			i	
	representative. 3. Ol	btain consent from the		4		i	
		ent representative. 4.		1		1	
	Obtain physician order for side rail/bed rail. 5.		i				
	Update the care plan and kardex. 6.		100	- 1			
	Re-evaluate the use of side rail/bed rail, quarterly,						
	with a change in condition or as needed. 7.		1				
	Follow the manufactu	1	- 6				
		alling and maintaining side					
	rails/bed rails."	dress routine or periodic		1			
		pections of side rails and I not have a manual of the					
	manufacturer's recon			1			
		side rails. The facility was				9	
		ing routine or periodic bed		1			
	and side rall inspection						
	On 6/20/22 at 42:40 I	DNA A CNA (a desiminate esti-		1			
		PM, ASM (administrative e executive director, ASM #2,					
		g and ASM #3, the Regional					
		ervices were made aware of					
	the above concerns.	or vious word made awars or				1	
	No further information	n was provided prior to exit.		İ			
						3	
	#96's bed for risk of e	iled to inspect Resident entrapment.				U _S	
	Resident #96 was ad	lmitted to the facility on				13	
		ses that included but were	i i			6	
	not limited to: morbid obesity and fibromyalgla.						
	Resident #96's most	recent MDS (minimum data					
		uarterly assessment, with an				i	
	,	ce date of 6/18/22, coded the					
		5 out of 15 on the BIMS					
		ental status) score, indicating					
		,	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	1, ,	(X3) DATE SURVEY COMPLETED	
		495203	B. WING			C	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC	7020		STREET ADDRESS, CITY, STATE, ZIP C 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302		06/29/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 909	G- Functional Status, requiring extensive as transfers. Observation of Residersident was resting if PM, 6/28/22 at 9:15 A Grab bars/assist rails be in use. On 6/27/22 at 5:00 Plevidence of the docursafety inspection for the resident in the following, "Grab the following, "Grab the following, "Grab the following, "Grab the following, "Grab the following, "Grab the following at the following rail (s) assist the resident in bed mobility and the following rail (s) assist the resident in the following rail (s) assist the resident in the following rail (s) assist the resident in the following rail (s) assist the resident in the following recommended." A review of Resident 11/1/18 revealed the (activities of daily living deficit related to debit in the following recommended the following rec	nitively intact. MDS Section coded the resident as saistance in bed mobility and ent #96 revealed the n bed on 6/27/22 at 1:30 kM and 6/29/22 at 8:15 AM. bilateral were observed to M, a request was made for mentation of the annual bed the entire facility. There was quested documentation for dated 10/19/21, revealed pars/assist rails bilateral to d repositioning." ail evaluation dated 1/26/22, g, "Bed mobility: will the bed dent in turning side to the side? Yes. Assist rail/grab bar #96's care plan dated following, "FOCUS: ADL 199) self-care performance ity, knee pain and VENTIONS: Side rails: 1/4	F	909			
	PM with Resident #96	e rails, Resident #96 stated,					

			(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		495203	B. WING		C 06/29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC		900 V	EET ADDRESS, CITY, STATE, ZIP CODE VIRGINIA AVENUE XANDRIA, VA 22302	06/29/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 909	Continued From page	84	F 909			
	PM with OSM (other a maintenance technical evidence of the annual OSM #2 stated, No, the stated, and the stated, well week, but we do not the previous director told computer and to not anything on paper. We given specific room a report of inspection for stated, no, there is not when asked for the norecommendation for the stated, no I do not when asked how OS per the manufacturers sure, this is my first time #2 stated, this is all the were provided a "TEL form which revealed to Mattresses: Inspect connum as necessary. Remoto prevent injury. Ver latch-knob assembly, latch is free of dirt and could impair its functi	ian. When asked for the all bed safety inspection, here is nothing in TELS by system) for all beds. Is checked on the beds, look at the side rails every track the bed rails. The me everything was in the worry about tracking when asked if OSM #2 was and bed numbers, could a per that bed be ran, OSM #2 to report for specific beds.				
	replace any parts suc screws, etc., that are or are missing." The facility policy, "Si	th as end caps, knobs, bolts, loose, show signs of wear ide Rail/Bed Rail" was documented, "Policy: The				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49520 3	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE COMPLETION DATE
F 909	document in the mediof side rail/bed rail. So but not limited to: Side rails, grab bars and as Prior to installation of the side rail/bed rail eresident for risk of entand benefits with the representative. 3. Obtain physician orded Update the care plan Re-evaluate the use of with a change in conditional formation of the policy did not additional formation of the policy did not additional for the not logging and tracking and side rail inspection on 6/29/22 at 12:40 Fix staff member) #1, the the director of nursing Director of Clinical Sethe above concerns. No further information 4. Resident #45 was bilateral half length side rails.	ternative interventions, and ical record, prior to the use side rails, bed rails, safety saist bars. Procedure: 1. a side rail/bed rail complete valuation to evaluate the trapment. 2. Review the risk resident and/or resident obtain consent from the ent representative. 4. or for side rail/bed rail. 5. and kardex. 6. of side rail/bed rail, quarterly, dition or as needed. 7. Iters' recommendations and alling and maintaining side dress routine or periodic pections of side rails and not have a manual of the mendations and side rails. The facility was no routine or periodic bed ons. PM, ASM (administrative rexecutive director, ASM #2, and ASM #3, the Regional process were made aware of the was provided prior to exit.		909	
		The facility was not able to d inspections were done to he side rails.	and the second second	÷	3. 3.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495203	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			STREET ADDRESS, CITY, STATE, ZIP (900 VIRGINIA AVENUE ALEXANDRIA, VA 22302	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE COMPLETION DATE
F 909	Continued From pag	e 86	F	909	
	quarterly assessmer Reference Date) of 4 a 13 out of a possible Interview for Mental coded as requiring s extensive to total caractivities of daily living. On 6/27/22 at 2:30 F observed in bed with up bilaterally. A review of the clinic physician's order dataside rails to aid in possible rails assessments con 4/28/21, 7/21/21, and An "Informed Consecompleted on 2/10/2 A review of the comprevealed one dated has an ADL (activities performance deficit included an interven revised on 2/10/21 for side rails to aid in possible rails to aid in po	PM, Resident #45 was a bilateral half length side rails all record revealed a led 2/10/21 for "Bilateral 1/4 sittoning and mobility." In clinical record revealed side expleted on 2/10/21, 3/9/21, and 10/21/21. Int for Use of Bed Rails" was all. In the care plan all for "[Resident #45] as of daily living) self-care are plan and the care plan and the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		\{\bar{\}}	(X3) DATE SURVEY COMPLETED	
		405000	B, WING		j	С	
		495203	B. WING _	· · · · · · · · · · · · · · · · · · ·		06/29/2022	
NAME OF PE	ROVIDER OR SUPPLIER		ŀ	STREET ADDRESS, CITY, STAT	re, ZIP CODE		
ENVOY OF	FALEXANDRIA, LLC		1	900 VIRGINIA AVENUE			
				ALEXANDRIA, VA 22302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION IVE ACTION SHOULD BE DED TO THE APPROPRIAT FICIENCY)		
F 909	Continued From page	97		200			
1 000	· -			009			
	-	components were inspected					
		room number and date of	Î.				
	•	ked about a manufacturer's	5 6 4				
		ndations and specifications,	i	l -		ļ	
		oes not have one. She	4	ll de			
		ot had a maintenance				81	
		nonths and was told not to	į	i		- A.	
		on paper, just follow what is	1			1	
	in the electronic main	itenance system.				5	
	OSM #2 than provide	ed a print out from the	į				
	•	aintenance system. A review	į			1	
		ent revealed instructions for					
		and side rail inspections but				1	
		that any actual inspections	ļ			i i	
		of inspections. It also did	i			i i	
		ency of conducting the	9			1	
		cument, "Beds & Mattresses:				1	
		cumented, "Maintenance	ļ			j i	
		ectors on rails and tighten	İ	*		1	
		ove any burs or rough edges	T				
		rify the function on the spring				(i)	
	latch-knob assembly	, if applicable. Ensure the				1	
	latch is free of dirt an	d/or foreign material that	i			i	
	could impair its functi	on. Ensure that the rails	1	1		1	
	engage and lock as a	specified. Tighten, adjust or		8		1	
	replace any parts suc	ch as end caps, knobs, bolts,	4			1	
		loose, show signs of wear	3				
	or are missing."						
			1			i	
		ide Rall/Bed Rail" was	1	4		i	
		y documented, "Policy: The	1	1		1	
		Iternative Interventions, and		1			
		lical record, prior to the use		1		9	
		Side rail/bed rail may include					
		de rails, bed rails, safety					
		assist bars. Procedure: 1.		1			
		f a side rail/bed rail complete		1			
	the side rail/bed fall (evaluation to evaluate the		1			

	or or medicine or	VIEDICAID SERVICES				OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495203	B. WING_		-	C 06/29/2022	
	ROVIDER OR SUPPLIER FALEXANDRIA, LLC			900 VIRGINIA AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	· (EAC	ROVIDER'S PLAN OF CORRECTH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 909		trapment. 2. Review the risk	FS	09		:	
	representative. 3. Ob resident and/or reside Obtain physician orde Update the care plan Re-evaluate the use of with a change in cond Follow the manufactu	er for side rail/bed rail. 5.					
	conduct any routine of inspections of side rad documentation of the did not have a manual recommendations an rails as documented in	dress when and how to or periodic maintenance and ils and beds and tracking se inspections. The facility of the manufacturer's d specifications for the side in the policy. The facility racking routine or periodic ections.					
	(Administrative Staff I Director, ASM #2 the ASM #3 the Regional Services, were made	imately 1:00 PM, ASM #1 Member) the Executive Director of Nursing, and Director of Clinical aware of the findings. No					